# BARRIERS AND ENABLERS TO ACCEPTANCE OF VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES BY YOUTH MALES

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Thesis submitted in partial fulfillment of the requirements for the degree of Masters of Philosophy (Community and Development) at the University of Stellenbosch.

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April 2006

**Statement**

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature: ……..

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## Summary

Voluntary Counseling and Testing (VCT) is considered an important component of the South African government's response to the HIV/AIDS pandemic. Despite of this, the numbers of South Africans who have accessed VCT remains low. Pregnant women in antenatal clinics remain the primary recipients of HIV testing since it is routinely offered to them at antenatal clinics. Figures from antenatal clinics constitute the most important source of HIV/AIDS statistics in South Africa. Targeting women at antenatal clinics perpetuate the stereotypes that women are solely responsible for reproductive health issues or, that they are to be blame for the mounting HIV infections. These beliefs exacerbate the culminating violence against women.

According to observation, active involvement of male youth in reproductive health at the Rosedale Clinic situated in Uitenhage, a town in the Eastern Cape, appears to be very limited. This might be as a result of traditional beliefs declaring reproductive health a primarily female domain. Active involvement of males in reproductive health is considered to have positive health outcomes both for themselves, and their partners. The purpose of this study is thus to encourage males served by the Rosedale clinic to become more actively involved in one aspect of reproductive health, namely voluntary counseling and testing (VCT). The study aims to find out which factors constitute barriers and enablers to VCT acceptance by male youth.

Semi-structured, face-to- face interviews were conducted in September 2006 with eighteen males, 18 to 25 years, to determine from their perspective what constitute barriers and enablers to HIV test acceptance by males. These participants were recruited from two well-known rugby clubs in Uitenhage, located in the Eastern Cape. In addition, a focus group discussion was conducted with four males recruited at a graduate development programme hosted in Uitenhage in order to explore common themes emerging from interviews and the discussion.

A pervasive, psychologically rooted fear; and possible low perception of risk emerge from this study as main barriers to HIV testing. Negative perceptions regarding service delivery in the public health sector constitute another barrier to HIV testing. The possibility of teasing, a common phenomenon amongst rugby players but not exclusive to them, exacerbates peer pressure thus possibly contributing to low levels of HIV test acceptance among these males. Increased HIV test acceptance is associated with increased opportunities of exposure to HIV testing opportunities, for example at awareness campaigns. Access to medical aid and income is also associated with an increased likelihood of HIV testing since most males prefer accessing HIV testing services in the private sector. Convenience and ease of access to HIV testing services are important when these males consider going for HIV testing.

**Opsomming:**

Vrywillige Berading en MIV Toetsing, een aspek van reproduktiewe gesondheid, word beskou as ‘n belangrike komponent van die Suid-Afrikaanse regering se strategie teen MIV/VIGS. Ongeag van hierdie feit is ‘n groot aantal Suid-Afrikaners nog nie getoets vir MIV nie. Swanger vrouens word op ‘n daaglikse basis hierdie toets aangebied as deel van roetine ondersoeke. Syfers vanaf pre-natale klinieke vorm die hoofbron van Suid-Afrika se HIV/VIGS statistieke. Die feit dat swanger vrouens die hoofteikengroep is vir MIV toetsing dra by tot stereotipes wat daartoe lei dat vrouens primêr verantwoordelik is vir die behoud van reproduktiewe gesondheid; en dat hulle beskou word as die hoofverdagtes in die toenemende oordrag van MIV. Laasgenoemde beskuldiging vererger geweld teen vrouens.

Volgens waarneming by Rosedale publieke kliniek geleë in Uitenhage, ‘n dorp in die Oos-kaap, is veral jeugdige mans se betrokkenheid in reproduktiewe gesondheid uiters minimaal. Dit kan moontlik wees omdat reproduktiewe gesondheid tradisioneel as ‘n vroulike domein beskou word. Aktiewe betrokkenheid van beide mans en vrouens in reproduktiewe gesondheid het positiewe gesondheidsuitkomste vir beide partye tot gevolg. Die doel van hierdie studie is dus om jongmans wie deur die Rosedale kliniek bedien word aan te moedig om meer sigbaar te word in reproduktiewe gesondheidskwessies; met die oog op een aspek daarvan naamlik, vrywillige berading en MIV toetsing. Die studie poog dus om uit te vind watter struikelblokke jeugdige mans weerhou van MIV toetsing en; watter faktore mans aanmoedig om vir die toets te gaan.

Semi-gestruktureerde, aangesig-tot- aangesig onderhoude is in September 2006 met 18 mans, vanaf die ouderdomme 18 tot 25 jaar, gevoer. Hierdie mans was tydens die studie rugbyspelers vanuit twee welbekende rugbyklubs op die dorp. ‘n Addisionele fokus groep is verder gevoer met manlike studente wie ten tye van die studie aan ‘n ontwikkelingsprogram vir gradueerders deelgeneem het op die dorp. Hierdie fokusgroep is geloods om soortgelyke temas vanuit die onderhoude en die bespreking te ondersoek.

Die studie toon dat ‘n diepgewortelde, sielkundige vrees; en moontlike lae bewustheid van persoonlike risiko die twee vernaamste struikelblokke is vir MIV toetsing. Negatiewe sienings rakende die publieke gesondheidssektor kan moontlik bydrae tot weerstand teen MIV toetsingsdienste. Tergery, ‘n bekende verskynsel onder rugbymans, maar nie slegs beperk tot diè groep nie, dra by tot groepsdruk en weerhou moontlik menige mans van MIV toetsing. Diegene in die studie wie alreeds vir MIV getoets is geniet toenemende blootstelling aan MIV toetsingsgeleenthede; bv tydens bewusmakingsveldtogte geloods òf by die werk òf tersiêre instellings. Toegang tot ‘n mediese fonds; en ‘n inkomste is moontlike bepalende faktore sienende dat meeste respondente gesondheidsdienste in die privaatsektor verkies. Gerieflike toegang tot MIV toetsingsdienste word deur sommige mans as belangrike beskou wanneer hulle MIV toetsing oorweeg.

## Acknowledgements

Thank you heavenly Father for granting me the strength to complete this thesis; it would not have been possible without you. Thanks for continuously reminding me that I can do all things through you who strengthen me. All honour and glory to you Daddy!

Prof. Ewert, thank you for believing in me even at times when I've doubted my own abilities. Thanks for the academic support, guidance, insight, patience, kindness, and encouragement.

Thank you Sr. K. Palmer for the support and sharing your wealth of knowledge on HIV/AIDS with me; it is appreciated. You are one of my role models.

Thank you to Aunty Deborah [one of the VCT counselors at the Rosedale Clinic] for granting me assistance at the last minute and being so passionate about what you do. Your selfless compassion inspires me.

Thank you to the management of Gardens and Progress rugby clubs who took the time to lend me an ear, and granting me permission to conduct research amongst their players. A special thanks to all those rugby players from both clubs who volunteered to participate in this study- guys without you this study would not have materialized. You are truly the best! I don't know which team I am going to shout for when I go to watch a match.

Thank you to the guys from the Graduate Development Programme who took out the time to participate in the study. I value your insight.

Thank you to my neighbours in Malgas Street, Uitenhage, my friends and spiritual family (Palace of Praise Ministries) who supported me throughout this process either through prayer, a word of encouragement, and a vote of confidence. I love you all!!

Last, but definitely not least, thank you to my parents and sister who supported me through this time. They were the people who had to endure my mood swings at times when I was stressed. Please forgive me for those times that I was just impossible to live with. Thank you "Mamma" for the cups of coffee, and washing dishes on behalf of me just so that I could finish my thesis in time. Thanks for sacrificing your last and best so that I could succeed in life. Thank you "Pappa" for working long hours so that we can have the best. Thanks for teaching us discipline and the value of education. Thanks Nita for the encouragement and for listening and for being there- you are the best sister in the world. I could not have asked for a better family. I love you!

Thank you to my cousin, Jolene Helmey, who literally walked with me, sometimes in scorching heat, to the respondent's houses in order for me to conduct interviews. Jo-Jo you are the best! I really love you! Thanks Nene (Katy Mintoor), Gavin and Rochelle for your endless support and commitment to helping me succeed. I am more than blessed to have you in my life.

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# CHAPTER 1

## BACKGROUND AND MOTIVATION

HIV/AIDS is the most fatal enemy of the entire global community. Millions of lives, worldwide, are lost to this virus on a daily basis and the war is still continuing. In 2005, an estimated 40.3 million people were found to be HIV positive globally (Journaids, 2005). During the same year 4.9 million new cases were reported, while three million people died of the dreaded disease. Recent estimates suggest that of all people living with HIV in the world, six out of every 10 men, eight out of every 10 women, and nine out of every 10 children are in Sub-Saharan Africa (South Africa, 2000-2005). These figures indicate that the majority of people living with HIV/AIDS are hosted by Africa.

South Africa constitutes the country with one of the highest HIV prevalence rates in the world. It is estimated that a total of 5.6 million South Africans acquired HIV by the end of 2002 (South Africa, 2003). The number of AIDS orphans is said to total one million. It is estimated that over 1600 new infections occur on a daily basis in South Africa and, approximately 900 AIDS-related deaths are reported every day.



Findings from a South African population-based survey indicate that the disease is race and gender biased with women bearing the brunt [Human Science Research Council (HSRC), Medical Research Council (MRC) & Centre for AIDS Development, Research and Evaluation (CADRE), 2005]. Women are more susceptible to the virus due to their continuing economic and social marginalization; as well as physical vulnerability. HIV prevalence rates for South African females and males are 13.2 %, and 8.2% respectively. The highest infection rates and the highest HIV prevalence, 16.9%, are amongst female youth aged 15 to 24 years. The 2005 National Antenatal Survey conducted in South Africa estimates that nationally, 30.2 % of pregnant women tested HIV positive in that year; with an increase in HIV prevalence amongst women in the 30-39 age category. African women, however, continue to be the most harshly affected. Women are increasingly blamed by men for the spread of the epidemic. The fact that women are

targeted at antenatal clinics for VCT, the driving force behind South Africa's HIV testing initiative, perpetuates this stigma and reinforces the stereotype of women being the primary stewards of reproductive and sexual health.

Primary emphasis on women as sole stewards of reproductive health issues is premised on traditional, patriarchal family planning views stating that women are the ones becoming pregnant (Maharaj, 2000) and, on findings that women are generally more motivated than men to protect their own reproductive health (Dreggan, cited in Maharaj 2000). These traditional views resulted in minimal investment in men's health and, until recently, men were viewed as mere obstacles to women's reproductive health (Maharaj, 2000). This might possibly explain the alienation of males from health care settings.

According to a study (Bond, Lauby & Batson, 2000), for both women and men, going to the doctor appears to be associated with a greater likelihood of HIV testing. Their findings show that men were much more likely than women to be uninsured (40% of men vs. 21% of women), were more likely to report that they did not have a regular doctor or health care provider (27% of men vs. 10% of women) and were more likely to report that they have made zero visits to the doctor in the past year (28% of men vs. 13% of women).



Male absence in reproductive health was recognized at both the 1994 International Conference on Population and Development (ICPD) held in Cairo; and the 1995 Fourth World Conference on Women in Beijing (Maharaj, 2000). The purpose of these conferences was to advocate a human rights-based approach and equality for women concerning their fertility and, more visible, supportive and active involvement of men.

Male involvement in reproductive health is crucial since male sexual behaviour too often exert an immense influence on women's reproductive health. Adverse health outcomes for women are commonly associated with a lack of partner involvement and support, as well as inadequate communication between couples (Ford, Wiraman, Sumantera, Sawitri & Stahre, 2004: 493; Gage & Ali, 2005: 162). The majority of studies report that the

main reasons for secrecy about an HIV positive status among women are primarily a fear of being physically abused by their partners; a fear of blame and rejection (Van Dyk, & van Dyk, 2001). Hutchinson & Mahlalela (2003), focusing on VCT in the Eastern Cape, agree that women there are more concerned about stigma and partner violence than clinic characteristics as barriers to test acceptance; thus they are found to utilize VCT services to a lesser extent than their male counterparts.

Hence it is important to create greater awareness among males of the important role they occupy, alongside women, in maintaining reproductive health. Mutual ownership of reproductive health amongst women and men might reduce women's fear of violence and create favourable conditions for greater VCT utilization.

The purpose of this study is thus to ascertain, from the perspective of males, those factors constituting motivators and barriers to the effective utilization of Voluntary Counseling and HIV testing (VCT) services by males.

Chapter 2 is a review of VCT related literature. It informs the reader of the definition of HIV and AIDS; modes of transmission common to the South African context; and ways of preventing the rapid spread of the virus. A brief overview is provided of the various models of testing practiced in South Africa, emphasizing VCT as one of the most important methods of HIV prevention employed by many developing countries. VCT models are briefly described. Attention is given to VCT trends discerned in South Africa. This chapter reviews the costs and benefits related to HIV testing as important considerations in an individual's decision to test. Focus shifts to barriers influencing HIV test acceptance, based on previous research conducted both locally and abroad.

Chapter 3 illustrates the methodology employed in conducting the research. A description is given of the tool used for data collection; pilot testing; sampling procedures employed and participant selection. Problems encountered during data collection are briefly mentioned. Chapter 4 is an empirical description of the study context.

Chapter 5 presents an analysis of key study findings, and chapter 6 represents the interpretation and discussion of these findings. The latter chapter concludes the study and proposes certain recommendations for future reference.

Attached to the thesis are the following appendices:
Appendix A: Questionnaire employed during the study.
Appendix B: Table 5 illustrating the distribution of stigma as perceived by participants at the family and community level. The distribution provides insight into participant's personal stigmatizing attitudes.

# CHAPTER 2

## 2.1 WHAT IS HIV AND AIDS?

HIV is a retrovirus[1]; in other words it uses the body's own cells to reproduce itself. It attacks the white blood cells, primarily responsible for protecting the body against illness. The result is a weakened immune system; making it easier for opportunistic infections to enter the body. Many infected individuals remain healthy for a long time since it takes 3 to 10 years for HIV to damage the immune system[2]. HIV, when adequate care and treatment lack, progresses to Acquired Immune Deficiency Syndrome (AIDS).

The disease is acquired because it is not inherited; i.e. it is caused by the HI-virus. Immunity refers to the body's natural ability to defend itself against infection and disease. Deficiency refers to a condition where the immune system is very weak to the point where it can no longer defend itself against infections. A syndrome is a medical term for a collection of specific signs and symptoms that occur together and that are characteristic of a particular condition. After HIV has progressed to AIDS the infected individual's CD 4 count (amount of white blood cells) is less than 200 per cubic milliliter of blood. A healthy individual is characterized by a CD 4 count of plus/minus 800- 1200 per cubic milliliter of blood[3]. An individual with AIDS usually suffers from opportunistic infections such as Tuberculosis (TB), Pneumonia and other rare cancers, once the immune system has severely deteriorated.

The HI-virus is detected through an HIV antibody test. After exposure to the virus the body produces antibodies in response to the virus within 3 to 8 weeks of infection. There is however an initial period during which specific antibodies to the various virus proteins or antigens has not yet been produced. This is known as the window period (Corbitt, cited in Bennett & Erin, 1999: 21). It is therefore possible for individuals to falsely test

[1] Source: http://www.journaids.org/hivaidsoverview.php#whatishiv
[2] Source: http://www.healthinsite.net/health/HealthProfile.dll/eCareCentreDetail?fh=1406
[3] Source: Lovelife Magazine, Uncut, April 2006, p. 26

negative during this period and, as a result people are encouraged to go for a confirmatory test three months thereafter.

## 2.2 HISTORICAL BACKGROUND AND THEORETICAL PERSPECTIVES OF THE ORIGINS OF HIV/AIDS[4]

The first cases of AIDS erupted in 1981 in the United States as a very rare form of Pneumonia. Characteristics common to all infected patients included the fact that they were all young, homosexual men with damaged immune systems. Shortly thereafter a disease, also affecting the immune system and causing diarrhea and weight loss was identified among heterosexual people. In 1983 it was ascertained that a virus caused the disease. It was only in 1986 that the virus was named HIV (human immunodeficiency virus).

There are two strains of the HI-virus: HIV-1 and HIV-2. The former is associated with infections in Central; East and Southern Africa; North and South; Europe and the rest of the world. HIV-2 is primarily restricted to West Africa. The two strains are structurally similar but HIV-2 is less pathogenic than HIV-1 and, HIV-2 infections have a longer latency period with slower progression to disease, lower viral load and lower rates of transmission.

There is still a great deal of uncertainty regarding the origins of the HI-virus. Two main theories concerning the origins of the AIDS epidemic (Van Dyk, 2005) are currently available. The first theory holds that AIDS is not a new disease but it has been present for centuries in central Africa. It could not be detected due to the lack of diagnostic facilities. Its symptoms were ascribed to Malaria and TB. One argument against this theory is that modern testing of archived blood samples from Africa rarely shows any signs of HIV infection prior to the 1980's. Doctors holding many years of clinical experience in Africa who claim that they have never seen diseases resembling AIDS related characteristics prior to the 1980's support this argument.

[4] Extracted from: Van Dyk, A.: HIV/AIDS Care & Counselling- A Multidisciplinary Aproach, Cape Town, 2005, pp. 4-5.

The second theory states that HIV crossed the species barrier from primates to humans at some time during the twentieth century (Korber, cited in Van Dyk, 2005). HIV is related to Simian immunodeficiency virus (SIV) found in primates. The sooty mangabey virus (SIVsm); one of the strains of SIV represents the closest relationship to an HIV strain, specifically HIV-2. HIV-2, as previously mentioned, was discovered in West Africa, interestingly enough home to the sooty mangabey monkey. There is, however, no clear link between SIV and HIV-1. One of the explanations offered on how the virus was transmitted from primates to humans holds that contaminated animal blood entered cuts on the hands of people who were butchering SIV-infected animals for food.

## 2.3 TRANSMISSION OF HIV AND FACTORS FUELLING RAPID TRANSMISSION IN SOUTH AFRICA

The primary modes of HIV transmission includes transmission from one individual to another, mainly during unprotected vaginal or anal sexual intercourse through bodily fluids such as blood, semen, and vaginal fluids, and other fluids containing blood. The virus can be transmitted from a mother to her unborn baby during pregnancy or during the birth process and through breast milk. Individuals further run the risk of being infected with the HI-virus when they share needles contaminated with HIV infected blood to inject drugs or, when an opening in the skin comes into contact with HIV infected blood. The virus can also be transferred during oral sex through cuts, lesions or open sores in the mouth. HIV transmission through a blood transfusion is not very common in South Africa since donated blood undergoes stringent screening processes as stipulated by the World Health Organization. In rare instances where blood is contaminated there is a 90-95% chance that someone receiving blood from an HIV positive donor will become infected with HIV themselves (WHO cited in Van Dyk, 2005). A person donating blood cannot be infected with HIV unless contaminated needles are used.

Transmission of HIV in South Africa is exacerbated by certain cultural practices and flawed cultural beliefs. The use of non- sterile needles and objects, for example, during initiation ceremonies signifying transition to manhood poses as possible vehicles for

HIV. Certain African societies and cultures view “skin-on-skin”, i.e. sexual intercourse without a condom, as a necessary prerequisite for optimal sexual satisfaction (Chirwa, (cited in Mkosi, 2000: 7). Some African cultures falsely believe that HIV/AIDS is an inevitable curse from the ancestors over which the individual has no control; hence no precautions are taken by certain individuals to prevent infection.

Migrant labour or movement occupations are also singled out as catalysts behind the rapid spread of HIV in South Africa (Mkosi, 2000). Mine workers or long distance truck drivers spend long periods away from home and, in the majority of cases, engages in intimate relationships with high risk partners such as commercial sex workers. Overcrowded prisons in South Africa where high-risk sexual practices such as unprotected anal intercourse are common are considered breeding ground to this deadly virus. More than half of the South African population is subjected to abject poverty, and although poverty does not directly cause HIV infection, it is said to fuel the rapid spread of the virus.

HIV cannot be transmitted through the following routes[5]

- Airborne routes such as coughing and sneezing. Precautions should however be taken in the case of TB when the sputum contains blood.
- Casual contact such as hugging, touching and shaking hands. The virus needs and entry point such as an open cut or tear in the skin.
- Sharing food, water, cutlery, cups, plates, toilet seats, clothing, bed linen, towels, showers or baths with an HIV infected individual. Sharing telephones, drinking fountains and public transport with infected individuals.
- Swimming in the same swimming pool as an HIV positive individual- Chlorine destroys, and water dilutes the virus.
- Playing team sports- Individuals involved in contact sports run a minimal risk of infection if HIV infected blood from the injured team mate that they are assisting finds entry into an open cut on their skin.
- Restaurants and cafeterias. Heat and gastric juices destroy the HI- virus.

[5] Myths about the transmission of HIV: Ibid, p35-36.

- No evidence has been found that the virus can be transmitted through kissing (unless intra-oral bleeding occurs), saliva, tears, sweat, or via insects such as mosquitoes according to the US Centers for Disease Control and Prevention (Journaids, 2006).

## 2.4 TREATMENT AND PREVENTION

There is currently no known cure for HIV/AIDS but despite of this, HIV remains one of the most preventable viruses. Disturbing myths propagated in certain communities regarding the cure of HIV infection include having sex with very fat women (Van Dyk, 2005), or with virgins including babies. Antiretroviral therapies (ARV's) are available and when used in conjunction with a healthy lifestyle, it can prolong an infected individual's live, slowing down the progression from HIV to AIDS. Abstaining from penetrative and anal sexual intercourse can prevent the spread of HIV. Mutual Monogamy; i.e. having sex with only one partner after both partners have tested negative for HIV and remain faithful to each other represents an alternative to preventing HIV transmission. Individuals can further protect themselves and their partners from HIV infection by wearing condoms during sexual intercourse at all times. Voluntary Counseling and Testing (hereafter referred to as VCT) remains an important cornerstone of the South African government's strategic plan in the management of HIV/AIDS.

## 2.5 VOLUNTARY COUNSELING AND TESTING (VCT)

### 2.5.1 HIV Testing and Informed Consent

The South African Department of Health's Draft Policy on HIV Testing, 1990, clearly stipulates that no individual should be coerced into accepting HIV testing due to the serious implications of an HIV positive result. The policy places emphasize on informed consent and individual autonomy (in line with the South African constitution: s12 and s14, Constitution of the Republic of South Africa, Act No. 108 of 1996) as prerequisite for HIV testing. Informed consent means that the individual has been provided with information; they have understood it; and based on this they agree or disagree to undergo the HIV test. It implies that the individual understands what the test is; what the

objectives and the purpose of the test are; and what the benefits, risks, alternatives, and possible social implications of the outcome are.

### 2.5.2 Conceptualization of Voluntary Counseling and Testing (VCT)

'Voluntary' refers to testing sought autonomously by an individual, i.e. in the absence of any form of coercion and/or manipulation, with the purpose of testing for the presence of HIV antibodies in the bloodstream. Voluntary includes practicing the right to informed decision making. Counseling is provided prior to the test (pre-test counseling), and after receiving the result (post-test counseling). The purpose of pre-test counseling is to equip the individual with sufficient information in order to make an informed decision about having the test or not. Post –test counseling is designed to inform individuals on how to live positively with HIV or how to maintain a negative result. Testing refers to the process where a blood specimen is taken from the individual presenting for VCT. In South Africa the most commonly used test is the Rapid Test (finger-prick test), which provides a result within 10-30 minutes. In case of a positive result, the result is confirmed by the ELISA test.

In a review of all published and unpublished literature concerning VCT in Africa (Solomon, Van Rooyen, Griesel, Gray, Stein & Nott, 2004) the conceptualization of VCT in unpublished literature is investigated. Unpublished literature refers to theses, dissertations, newspaper articles and/or advertisements, government policies, pamphlets or reports and unpublished organizational research, pamphlets or reports. The following meanings evident from their review are constantly ascribed to VCT:

a) *VCT as prevention strategy*

This definition describes the role of VCT in primary and secondary prevention of HIV transmission. The former refers to facilitating behaviour change in those testing HIV negative, and the latter to facilitating behaviour change in HIV positive individuals. The aim is to encourage those testing HIV negative to remain that way, and to prevent further illness in those diagnosed as HIV positive through informative and educational counseling sessions.

b) *VCT as promoter of health*

VCT allows early detection of the HI-virus, which enables access to the appropriate information, treatment and care systems aimed at advancing individual's ability to manage the disease.

c) *VCT as psycho-emotional support*

VCT allows access to psychological and emotional support services for HIV infected individuals; their friends and families. It advocates messages such as 'living positively with HIV.

d) *VCT as process of informed consent*

During pre-test counseling the client is provided with all the relevant information in order to make an informed decision on whether they wish to test or not.

e) *VCT and stigma reduction*

The rationale behind this is to "normalize" HIV/AIDS as disease, i.e. encouraging people to view and treat it as any other chronic and terminal illness; and to de-stigmatize HIV testing services by encouraging more people, irrespective of risk category, to accept testing. In a study evaluating the implementation of VCT at the primary health care level in rural South Africa (Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler, 2001) it was found that 94% of health care workers reported that their colleagues are more accepting toward those living with HIV after the introduction of VCT. Prior to VCT, 50% commented colleagues were fearful and 33% stigmatizing towards clients.

### 2.5.3 VCT Models

There are six different VCT models (Cairncross, 2005). These are:

- *Stand-alone sites*- This is a site functioning independent of a medical institution.
- *Integrated model*- This site is commonly associated with public sector health care services.
- *The NGO model*- VCT forms part of the NGO's established activities.
- *The Private Sector model*- This model is lodged within private sector health care and is generally perceived as private and confidential.
- *The Mobile/Outreach model*- A mobile van (usually a caravan) is used to render VCT services at designated places.
- *The Workplace-based model*- It is operative on the premises of the institution, company or organization where the individual works and is a link to care and treatment.
- *The Integrated antenatal model*- This model is found primarily in public health clinics and its aim is to reduce and prevent transmission from mother to child.

Individuals' decision to undergo HIV testing is influenced and determined by weighing up the costs and benefits linked to HIV testing.

## 2.6 THE COSTS AND BENEFITS OF HIV TESTING

HIV/AIDS is an epidemic that has serious ramifications for an individual, community and society. The disease is plagued with widespread stigma and discrimination; the result of inadequate knowledge regarding the epidemic, fear and ignorance. Careful attention should hence be given to the costs and benefits accompanying HIV testing and, the outcome of the test. Manuel (cited in Bennett & Erin, 1999) discerns psychological- and social costs and benefits for three types of individuals: individuals facing no risk of contracting HIV; at-risk individuals testing HIV negative and asymptomatic individuals

found to test HIV positive. Cognizance is given to the costs and benefits of testing at the community level.

### 2. 6.1 No Risk Individuals

These individuals, according to Manuel, refer to those refraining from any high risk practices such as unprotected sexual intercourse; and engage in safe sexual practices such as mutual monogamy; or abstaining from any sexual relations. Manuel states that it is highly unlikely that these individuals will seek out HIV testing, and will therefore not benefit from HIV testing. This statement is supported by previous studies stating that individuals practicing no, or low risk behaviours or having a low perception of risk are not likely to go for HIV testing (Flowers & Church, 2002: 52; Exner, Hoffman, Parikh, Leu & Ehrhardt, 2002:79; Campbell & Bernhardt, 2003: 544; Inungu, 2002: 293; Burns, 2004: 499; Lopez-Quintero, Shtarkshall & Neumark, 2005: 675; Glick, Silva, Zun & Whitman, 2004: 131 & Wurcell, Zaman, Zhen & Stone, 2005: 502).

The South African population based survey, conducted in 2005, similarly shows that individuals with a low perception of risk are less likely to go for HIV testing. The opposite of this can also be true. No risk individuals might feel more motivated to test since they anticipate a negative result and experience minimal stress and anxiety. Manuel (cited in Bennett & Erin, 1999) identified the effects of coerced testing and the effects of a false HIV positive diagnosis (eliciting fear, anxiety, shock, etc.) as possible harms that no risk individuals might experience. Mistakes such as the latter are possible since HIV tests are highly sensitive in favour of avoiding false HIV negative diagnosis.

### 2.6.2 Individuals at Risk Testing HIV Negative

According to Manuel (cited in Bennett et al, 1999) these individuals benefit a great deal from HIV testing; especially psychologically. News such as this offers relief, reassurance and peace of mind to an individual who were anxious due to uncertainty regarding his/her HIV status, and anticipated a positive result. Exposure to HIV/AIDS education during counseling; and this close encounter with life as an HIV positive individual is expected to

prompt the individual into adopting safer sexual behavioral practices. It might also evoke the opposite response in the individual; thinking that if I was lucky enough to get away with it this time, I might be lucky the next time (Manuel, cited in Bennett et al, 1999: 64). The literature produces mixed findings and uncertainty regarding the effects of HIV counseling on high-risk behaviour; i.e. in its role to contain the spread of HIV by motivating behavioural changes. Some studies show a reduction; others no significant change; and others an increase in the incidence of high risk behaviour (Exner et al, 2002: 76; Roark, Webster, Darrow & Stempel, 2005: 18; Brown, O'Grady, Farrell, Flechner & Nurco, 2001: 1594; Ginwalla, Grant, Day, Dlova, Macintyre, Raggaley & Churchyard, 2002: 707; Ford et al, 2004: 489; Myers, Worthington, Haubrich, Ryder & Calzavara, 2003: 310; Flowers, 2003: 184; Renzi, Zantedeschi & Signorelli, 2004: 102, Stein & Nyamathi, 2000: 344 & Jiraphongsa, Danmoensawat, Greenland, Frerichs, Siraprapasiri, Glik & Detels, 2002: 90). One consistent finding in the literature evident from a literature review on VCT in Africa is that VCT is more effective in facilitating behaviour change in those testing HIV positive than those testing negative (Solomon et al, 2004). In a study conducted by Van Dyk & Van Dyk (2001) the majority of people stated that they would not change their behaviour if they tested HIV negative and some of the reasons included: "It is obviously not necessary".



### 2.6.3 Individuals Testing HIV Positive

The costs and benefits related to an HIV positive diagnosis are of a psychological; social; therapeutic and a preventative nature.

*a) Psychological*

Prior to the introduction of Anti-retroviral Therapies (ARV's) individuals testing HIV positive faced the inevitable gloomy prospect of early ill health, and ultimately death. Currently, these therapies are proven to be effective in delaying the progression from HIV to AIDS. Hence, it is supposed to alleviate the psychological consequences following an HIV positive result. Post-ARV's some studies indicate that the majority of

individuals remain hesitant to find out their HIV status due to fear and anxiety of possible HIV infection. HIV positive participants in the South African population based survey, 2005, were more likely to feel empty or sad; than their HIV negative counterparts. Depression was found to be higher in individuals tested and found to be HIV positive (38.8%), than individuals unaware of their HIV status (31.3%). Contrary to these findings, other studies show that some individuals regard knowing your status as a way of relieving the stress caused by not knowing (Downing, Knight, Reiss, Vernon, Mulia, Ferreboeuf, Carroll & Vu, 2001: 566; Flowers, 2003; 183).

*b) Social*

HIV and AIDS are synonymous with stigma and discrimination. In a study (Herek, Mitnick, Burris, Chesney, Devine, Fullilove, M.T., Fullilove, R., Gunther, Levi, Michaels, Novick, Pryor, Snyder & Sweeney, 1998) AIDS-related stigma is referred to as 'prejudice, discounting, discrediting and discrimination directed at people perceived as having HIV or AIDS and; at individuals, groups, and communities with which they are associated. It is reported (Insideout Research cited in Holzemer & Uys, 2004) that stigma in South Africa 'can be felt, leading to unwillingness to seek help and to access resources. It can be externally acted out leading to discrimination on the basis of HIV status or association with someone who is living with HIV/AIDS'. Stigma is deeply felt by already stigmatized individuals or groups such as the poor, black people, women and children orphaned by AIDS. Solomon et al (2004) refer, for example, to a wealth of studies addressing women's reluctance to disclose their HIV status due to fear of a violent reaction. Other negative life events experienced by HIV positive individuals after disclosure of their HIV status include the break up of a marriage and being disowned by family members (Grinstead, cited in Solomon et al, 2004).

The levels of discrimination individuals experience are also determined by the mode of HIV transmission. This phenomenon is characterized by a judgmental discourse distinguishing between the innocent victims, for example a baby contracting HIV from the mother as oppose to those considered guilty and deserving of their illness such as

prostitutes and homosexuals (Skinner & Mfecane, 2004). De Bruyn (cited in Holzemer, 2004) holds that AIDS-related stigma is fuelled 'by the fact that AIDS is life-threatening; that people fear it; that it is associated with already stigmatized and frowned upon behaviours such as, for example, prostitution; and that people with HIV/AIDS are viewed by others as responsible for contracting the disease.'

Stigma induced incidents are also common sights in South Africa. Familiar incidents include the stoning of an HIV positive woman, Gugu Dlamini, in 1998 after making her status publicly known. More recently, in 2004, Lorna Mlofane was raped and later killed after her rapists learnt that she was HIV positive (Skinner & Mfecane, 2004). There are also known cases of health professionals refusing to treat people with AIDS due to fear of a possible risk of infection (Krautkramer, cited in Skinner & Mfecane, 2004). Stigmatizing attitudes persist towards people living with AIDS (PWA's). It became apparent in the findings of a South African national survey stating that '26% of respondents would not be willing to share a meal with a person living with AIDS; 18% were unwilling to sleep in the same room as someone with AIDS; and 6% would not talk to a person they knew to have AIDS (Kalichman & Simbayi, 2003).

Uncertainty regarding the origins and the future of the epidemic causes people to grapple with possible ways of making sense of it. Some people proactively engage with the epidemic in search of explanations; e.g. some might resort to conspiracy theories; while others choose to remain in denial, or ignorant about it altogether. The latter group often resorts to discrimination against PWA causing infected individuals to struggle more with the resulting stigma and discrimination than with the epidemic. HIV infected individuals can be consoled by the fact that the South African government has made Constitutional and legal provision for the protection of HIV infected individuals against discrimination. These, however, are not "bullet proof shields" against persisting stigmatizing attitudes and discrimination aimed at PWA. HIV infected individuals' lives, according to own opinion, are in the majority of cases shortened by stigma rather than the virus itself since some of them choose death by hiding their illness and failure to access crucial treatment

and care. Health care workers in Southern Africa concluded ‘that unless stigma is conquered, the illness will not be defeated (Uys, cited in Holzemer & Uys, 2004).

*c) Therapeutic*

It is common knowledge that there is currently no known cure for HIV/AIDS. Antiretroviral medicines (ARV’s) are prescribed for infected individuals in South Africa since 2004. The function of these medicines is to suppress the replication of HIV, allowing the immune system to strengthen and to combat opportunistic infections. It is estimated that HIV mutation may occur more than 10 000 times a day in an infected person (Department of Social Development, 2003). This causes the virus to evade the effects of ARV’s.

Individual compliance to the stipulated drug regimes therefore plays a vital role in the success of the drug to suppress the virus and to prevent ARV resistance; meaning that the medicines are no longer effective in suppressing HIV. The result is increased viral load and a weakened immune system. Some individuals might find it difficult to comply with demanding dosages. Another disturbing observation is that of HIV positive individuals abusing substances such as alcohol to relieve HIV/AIDS related stress and depression while on treatment; thus weakening the effect of the medicines. One of the requirements in the assessment of eligibility for ARV in South Africa includes whether the individual has the support of family members or friends in ensuring that the individual adhere to treatment. Similar to other medicines, ARV’s also have side effects such as nausea, vomiting, stomach pains, pain in the legs, nightmares, headaches, tiredness, skin rashes, imsomnia and diarrhea (Department of Social Development, 2003).

As at the end of March 2005, official government figures indicated that at least 42 000 patients were accessing ARV treatment in the public health sector, compared to between 50 000 and 60 000 in the private sector (AIDS Law Project & Treatment Action Campaign, 2005). There are provincial variations in access to ARV’s with KZN and Gauteng having the most patients benefiting from ARV’s. The Eastern Cape,

Mpumalanga and Limpopo show very little improvement in the number of people accessing ARV's since 2004. By the end of 2004, 3739 people benefited from ARV's in the Eastern Cape and the figure has raised to 4635 by May 2005- not a very dramatic increase.

The cruel reality remains, however, that the majority of South Africans are still struggling to get access to these medicines. The South African government has been criticized on numerous occasions for the slow rollout of antiretroviral treatment (Cape Argus, 22 May 2006, p. 4.). The current Minister of Health, Dr. Manto Tshabalala-Msimang, remains the object of harsh criticism by the international community (International AIDS Conference, Toronto Canada, 2006), her own colleagues and HIV/AIDS activists. She is accused of confusing and misleading the public regarding the role of nutrition in the treatment of HIV/AIDS.

Poorly resourced clinical settings and inadequately trained staff contribute to the mismanagement of ARV's, compromising the health of many individuals. Several individuals in a certain South African province, for example, could have been prevented from dying of AIDS-related meningitis if a certain drug was ordered by the provincial Department of Health. The drug was available in the country at the time of the crisis, but the provincial department of health neglected to order the drug as reported by the Herald (7 June 2006: 1). Some people take advantage of the opportunity and exploit HIV positive individuals by developing "miracle cures". HIV infected individuals are so desperate for a "quick fix", often resulting in great financial losses and sometimes death. Treatment-related problems might discourage people from accessing VCT and; it can further contribute to the existing psychological consequences and the resulting physical effects PWA's face on a daily basis.

Studies have indicated that HIV/AIDS medications are proven to enhance quality of life, and to prolong the lives of infected individuals (Hart, Williamson, Flowers, Frankis & Der, 2002: 665; Flowers, 2003: 739). Studies provide inconsistent findings regarding the influence of the availability of medication on people's willingness to access VCT. Some

studies indicate that the availability of ARV's or the knowledge of someone using it might motivate people to go for testing (Mfundisi, Chiranjan, Rodrigues, Kirchner, Bock & Myer, 2004: 483; Mashburn, Peterson, Bakeman, Miller & Clark, 2004: 53; Flowers, 2000: 740; Ford et al, 2004: 494, Mwamburi, Dladla, Qwana & Lurie, 2005: 524 & Spielberg, Branson, Goldbaum, Lockhart, Kurth, Celum, Rossini, Critchlow & Wood, 2003: 322). In a study investigating the influence of ARV availability on testing decisions of mine workers in South Africa (Day, Miyamura, Grant, Leeuw, Munsamy, Baggaley & Churchyard, 2001) the opposite was found. Participants still refused testing after they were informed about the availability of ARV's.

*d) Prevention*

VCT is found to have positive effects on the behaviour of especially HIV positive individuals. They are more likely to adopt safer sexual practices than individuals testing HIV negative (Weinhardt, cited in van Dyk & van Dyk, 2001; Coates, cited in Solomon et al, 2004). It is however the individual's right to decide whether to disclose HIV status; and to whom. Hence, it is realised that in some cases knowledge of HIV status might have a significant and positive impact on the individual's behaviour, while in other cases not. Kwa-Zulu Natal constitutes the province with the highest rates of HIV infection in the country and the youth bear the brunt of HIV infection. A study conducted by Leclerc-Madlala (1997) disturbingly revealed that Kwa-Zulu Natal youth's response to the epidemic is characterized by denial and avoidance of HIV diagnosis, while they are simultaneously desperate to spread the virus as widely as possible. This alarming response is interpreted against the cultural ethos of Ubuntu, and the strategies once employed by them to forge solidarity in their struggle against the Apartheid regime. They view HIV/AIDS as their new enemy and are determined to stand united against it by infecting one another.

### 2.6.4 Cost and Benefits of HIV Testing at the Community Level

HIV screening of targeted individuals for epidemiological purposes; in other words examining the evolution of the virus, are beneficial to the community since valuable data emerge from these campaigns. The identification of HIV infected individuals is considered crucial in ensuring that these individuals are treated. Once on treatment, their viral load reduces and they become less infectious and pose a minimal threat to society (Mashburn et al, 2004: 47). This scenario is easier said than achieved in South Africa since it is against individual rights to be coerced into going for testing. De Cock (cited in Strode, Van Rooyen, Heywood & Abdool-Karim, 2005) therefore holds that the notion of informed consent poses as a barrier to HIV test acceptance and that VCT should be available as part of a package of services for which the client is 'voluntarily' attending. Coercion is not deemed effective since it might lead to poor compliance to treatment; no co-operation from infected individuals; and distrust of medical authorities.

It should further be noted that routine or mandatory testing of only certain populations are said to lead to new stigma against those populations (Strode et al, 2005) and impinges further on their human rights. It is thus an issue of individual rights vs. that of the community. The tension exists among protecting the community from the danger of infection, while simultaneously protecting HIV positive individuals from stigma, ostracism and discrimination. Focus is now shifted to how individual weighing of the costs and benefits of HIV testing; and other factors have influenced VCT acceptance in South Africa.

## 2.7 VOLUNTARY COUNSELING AND TESTING TRENDS IN SOUTH AFRICA AND INTERNATIONALLY

### 2.7.1 Awareness of HIV Testing Services in South Africa

It is reported [Human Sciences Research Council (HSRC), Medical Research Council (MRC) & Centre for AIDS Development, Research and Evaluation (CADRE), 2005] that the majority of South Africans, 78.8% are aware of VCT services; and that an increase in the rates of testing has occurred since 2002. Similarly, in a population-based survey conducted in the Eastern Cape (Hutchinson et al, 2002/3) the majority of participants knew of a place where VCT could be accessed and 90% sited either the hospital or clinic as source of the test. This is due to improved accessibility and availability of VCT and treatment options. In the Eastern Cape, for example, it is reported (Hutchinson et al, 2005: 447) that the number of VCT sites has increased from 52 to 403 in a very short period of time and, interventions are increasingly dedicated to prevention of mother-to-child transmission.

### 2.7.2 Problems common to VCT

*Low Rates of Testing*

Despite high levels of awareness of VCT, people still avoid going for VCT. In 2002, the Nelson Mandela HSRC Study of HIV/AIDS has found that “only 19% of adults over the age of 15 had ever been tested for HIV/AIDS (Hutchinson et al, 2005: 447). In a nationally representative household survey conducted in 2003 among South African youth, from 15-24 years, 67 % of the youth indicated that they had never been tested for HIV. Disturbingly enough, 27 % of the youth reported that they do not want to find out their HIV results. Females were more likely to report having been tested for HIV compared to males. The HIV Prevalence, Incidence, Behaviour and Communication Survey (IBCS), 2005, similarly highlights that a large number of South Africans (12.8%), unaware of their status, are HIV positive. This finding is echoed in various studies stating that less than 20% of South Africans have been tested for HIV (Mfundisi et al, 2005:

483). Another study indicates that only one in five South Africans aware of VCT have been tested (Kalichman & Simbayi, 2003: 1). The majority of mine workers in a South African study remained reluctant to utilize VCT services offered at work even after the quality of services improved remarkably and more benefits were introduced (Day et al, 2001).

Lower levels of VCT utilization; and lower perception of perceived access to VCT services in South Africa is increasingly associated with residence in rural areas. In the Eastern Cape testing rates are the lowest in rural areas compared to the rest of the Province (Hutchinson et al, 2002-3). In rural areas exposure to HIV/AIDS messages remains scant due to limited access to popular media (television, radio, newspapers and magazines). Rural residents might thus not be sufficiently sensitized to HIV/AIDS; thus occupying more pervasive stigmatizing attitudes. It is further characterized as close-knit (everybody's in everybody's business); not allowing for much privacy. In a study conducted by Van Dyk et al (2001) participants living in rural areas were more likely to access testing at anonymous testing sites, i.e. where they are not known either to staff or fellow clients. They were also against being accompanied by someone for purposes of support when going for VCT; and were more inclined towards keeping their results secret.



Studies conducted in the rest of Africa agree that VCT utilization remains low. In a Zambian study it became apparent that where VCT has been made readily available, demand has been disturbingly low (Fylkesnes & Siziya, 2004: 567). Findings from a Zimbabwean study claims that the actual uptake of VCT in most of sub-Saharan Africa remains low (Morin, Khumalo-Sakutukwa, Charlebois, Routh, Fritz, Lane, Vaki, Fiamma & Coates, 2006: 2). Similar findings arise from other studies showing that no, or low uptake of HIV testing is a universal problem (Liddicoat, Horton, Urban, Maier, Christiansen & Samet, 2004: 349; Inungu, 2002: 293; Smith, Buzi, & Weiman, 2005: 451; Wurcel et al, 2005: 499 & Jiraphongsa et al, 2002: 98). People are not only aware of VCT services, but they generally show interest in being tested for HIV.

In the South African national youth survey conducted in 2003, 60 % of those 15-24 year olds reported that they are interested in finding out their HIV status. Similarly, in a study conducted by van Dyk & van Dyk (2001) among both urban and rural South Africans, 87% of participants believed that a person should know his HIV status. Fylkesnes & Siziya (1999), however, are of the opinion that there is a striking gap between what people say they would like to do, and what they actually do when services are offered. In their study 30% of the urban survey participants expressed their readiness (i.e. their interest in being tested), but only 4% of this group initially accepted (used) the services. In a review of literature on VCT in Africa, Solomon et al (2004) address this same phenomenon and they refer to a Zambian study conducted by Fylkesnes, Haworth, Rosensvard and Kwapa in 1999. These authors further found that although self-perceived risk and high-risk behaviours were positively associated with initial willingness to test, it did not culminate into the actual uptake of services.

*Late testing*

Another area of concern is the fact that when people eventually decide to go for HIV testing, they decide to do so when the virus has already rapidly progressed. Early testing refers to a situation where individuals had their first HIV positive test five or more years prior to, or without a diagnosis of AIDS (Rosenberg, 2003: 274). The following factors were classified as indicators of late testing in a study (Wong, Lee, Low, & Wan, 2002): AIDS within three months of HIV diagnosis, CD4 below 200 per cubic milliliter blood; and diagnosis at hospital. They assert that patients with late diagnosis should generally be more symptomatic than those with early diagnosis; and are therefore more likely to be referred to hospital. Reference is repeatedly made to late testing in the majority of studies (Glick et al, 2004: 134; Flowers et al, 2003: 739; Rosenberg, 2003: 274; Wong et al, 2002: 461 & Renzi et al, 2004: 102). In a South African study (Day et al, 2001) conducted among mineworkers, when asked the question: “When should a person be tested for HIV/AIDS”, most of the participants (51%) said when diseases such as sexually transmitted infections, TB symptoms, etc. start manifesting. The majority of participants previously tested in this study have done so because of illness. Wortley,

(cited in Stein et al, 2002: 2) ascribe late testing to lower suspicion of having the virus and, less awareness about testing or its availability. In another study (Mosen, Wenger, Shapiro, Andersen & Cunningham, 1993: 5), late testing was associated with lower self-reported access to outpatient medical care. Late testing can also result from fear anticipating the consequences of a positive result, or denial of possible HIV infection.

*No or low return for test results*

People are often discouraged by the long periods they have to wait for their test results. Prior to an intervention conducted among rural residents in South Africa (Pronyk et al, 1999) VCT was conducted primarily using the HIV ELISA test and individuals had to wait several days for their results. Hence, the majority of clients failed to return for the result. After introduction of rapid HIV-1/2 assays, return rates increased and clients even accessed testing voluntarily. Solomon et al (2004) mention several studies addressing these low return rates. This situation is, however, on the decrease since rapid testing is increasingly being used in the South African context.

The South African HIV testing policy states that individuals must consent to receiving their test results after they have been well informed about its consequences. Some individuals might therefore change their minds about accepting test results due to fear. Most studies indicate that some individuals prefer to practice their right to ignorance (Brown et al, 2001: 1594; Pronyk et al, 2002: 860; Lopez-Quintero, 2005: 672; Smith et al, 2005: 452; Hutchinson et al, 2004: 101; Stein et al, 2000: 344 & Spielberg et al, 1998: 318); and in that way they might be a possible threat to themselves and society.

*Infrequent testing*

Earlier in the review reference was made to the window period, basically referring to the period during which antibodies to the HI-virus cannot be detected in the blood. Some individuals might therefore present for HIV testing during the window period and might leave under the false impression that they are HIV negative, failing to return after three months. Individuals are therefore encouraged to return for a confirmatory test three months after the initial test especially in cases where they have been subject to possible

infection. Some individuals fail to do this and, consider a single test as more than enough (Stolte, Gras, Van Benthem, Coutinho & Van Den Hoek, 2003: 571).

## 2.8 BARRIERS AND MOTIVATORS TO VCT

### *2.8.1 Demographic characteristics*

Findings regarding the influence of demographic characteristics on HIV test acceptance are very inconsistent (Solomon et al, 2004). It is frequently reported that test acceptance, or early regular testing is associated with increasing age (29-39 years) [Johnson, Sorvillo, Wohl, Bunch, Harawa, Carruth, Castillon & Jimenez, 2003: 278; Fortenberry, McFarlane, Bleakley, Bull, Fishbein, Grimley, Malotte & Stoner, 2002: 379; Mashburn et al, 2004: 52 & Renzi et al, 2004: 105]. Late testing, or not testing at all are associated with both younger age (25 years and younger) [Stolte et al, 2003: 568; Johnson et al, 2003: 280; Inungu et al, 2002: 297; Hart et al, 2002: 667; Flowers et al, 2003: 744; Rosenberg, 2000: 274; Urassa, Gosling, Pool & Reyburn, 2005: 845; Renzi et al, 2004: 107; Kellerman et al, 2002: 204 & Jiraphongsa et al, 2002: 98]; and older age (50 years and older) [Iningu et al, 2002: 297; Gage et al, 2005: 156; Lopez-Quintero et al, 2005: 675; Vermund & Lancet, 2002: 1; Wong et al, 2002: 465). A possible explanation for this finding might be a lower risk perception amongst these groups; influencing their risk-reducing and preventative behaviour. Lower perception of risk was increasingly associated with younger, (15-24 years) and older age (50 years and older) in South Africa[6]

Increased acceptance of testing, or testing early is in the majority of cases associated with high levels of education (Hutchinson, 2003; Stolte et al, 2003: 566; Iningu et al, 2002: 297; Hart et al, 2002: 667; Gage et al, 2005: 156; Renzi et al, 2004: 105, Johnson et al, 2003: 278 & Fylkesnes et al, 2004: 568), while late, or no testing is frequently associated with low levels of education (Stolte et al, 2003: 568; Johnson et al, 2003: 280; Lopez-Quintero et al, 2005: 575; Rosenberg, 2000: 274). Findings from other studies report no

[6] HIV Prevalence, Incidence Behaviour and Communication Survey (2005)

significant relationship between levels of education and HIV testing (Flowers, 2000: 744 & Mashburn et al, 2004: 56).

Most studies report that a higher income might be indicative of an increased likelihood of testing, or testing early (Gage et al, 2005: 156; Johnson et al, 2003: 278). Some studies furthermore report no significant relationship between HIV testing and marital status; sexual orientation; and gender (Burns, 2005: 496; Mashburn et al, 2004: 56 & Glick et al, 2001: 130).

*2.8.2 Stigma and Stigmatizing Attitudes*

AIDS-related stigma remains a frequently sited barrier to testing. Most individuals refer to a fear of socially imposed discrimination and stigma, and its adverse consequences such as violence or rejection as common deterrents to HIV testing [Spielberg et al, 2003: 322; Mwamburi et al, 2005: 524; Fortenberry et al, 2002: 379; Flowers, 2003: 740; Ford et al, 2004: 492; Hutchinson, 2004: 109 & Urassa et al, 2005: 847].

In a study conducted in the Eastern Cape, (Hutchinson, 2005) the absence of stigma and knowing someone with HIV/AIDS were positively associated with increased acceptance of VCT. Knowing someone with HIV/AIDS is found to decrease stigmatizing attitudes towards people with HIV or AIDS (PWHA's). Other factors sensitizing people towards PWHA's, as discerned by the study, include involvement in caring for PWHA's and possibly the media.

*2.8.3 Fear, Denial and Survival*

The main reasons frequently sited for resisting testing primarily includes a fear of adverse consequences following a positive result. This fear mainly translates into a fear of death; fear of the psychological burdens such as depression; and a fear of rejection-either by relatives or society in general (Mwamburi et al, 2005; Ginwalla et al, 2000; Van Dyk et al, 2001; Downing et al, 2001: 570; Day et al, 2001: 668; Mwamburi et al, 2005: 524; Flowers et al, 2003: 745; Ginwalla et al, 2002: 713; Ford et al, 2004: 492; Urassa et al, 2005: 847; Hutchinson et al, 2004: 108 & Spielberg et al, 2003: 322].

In a study conducted by Van Dyk & Van Dyk (2001) fear had a different source for men and women. Women's fear was mostly related to issues of power, while men's fear was related to issues of sexuality and sex appeal. Women generally fear violence and rejection from their partners after disclosure while men fear being less attractive to women after testing positive.

Denial or ignorance regarding HIV/AIDS [Hutchinson, 2004: 109 & Flowers, 2003: 185] closely relates to this pervasive fear. Most people in abject poverty prefer not to know their HIV status since they are concerned about the ability and possibility to care and provide for themselves and their families after testing HIV positive (Solomon et al, 2004). People evade testing because they fear the outcome of the result until they show symptoms indicative of possible HIV infection. A lack of symptom manifestation might also delay test seeking. Most individuals present themselves for HIV testing when they feel ill; or when symptoms start to manifest [Myers et al, 1999; Stolte et al, 2003: 566). Siegel, cited in Flowers, 2002, found that individuals even after testing positive, delay seeking care and treatment if they feel healthy, and in the absence of symptoms. Meursing, cited in Solomon et al; 2004 holds that denial of HIV infection is more prevalent in symptom-free periods.



*2.8.4 Perception of Risk*

Low perception of risk to HIV infection, a very disturbing occurrence since South Africa has one of the highest HIV infection rates worldwide (HSRC, MRC & CADRE, 2005.), constitutes a barrier to VCT acceptance. In the national youth survey (2003) when youth were asked what their chances are of contracting HIV, 36 % believed that they were at no risk of contracting HIV; 35 % reported being at small risk; while 12% reported moderate risk; and only 14% reported high risk. In a study conducted by Day et al (2001) amongst mine workers in South Africa the majority (69%) of participants only perceived themselves to be at some degree of risk, while only 11% described themselves as being at high risk or infected. When the researchers posed the question, "Are there people working here with HIV/AIDS?" once again the majority of participants, 73 out of 105,

responded with no. This finding is echoed in studies conducted abroad [Downing et al, 2001: 571; Stolte et al, 2003: 568; Inungu et al, 2002: 296, Lopez-Quintero, 2005: 675; Glick et al, 2004: 131; Flowers, 2003: 745; Smith et al, 2005: 453; Kellerman et al, 2002: 205; Jiraphongsa et al, 2002: 99 & Downing et al, 2001: 567]. Solomon et al (2004) is of the opinion that the commonly made assumption of perceived personal risk as motivator to test is a flawed one. They refer to the findings of two studies (Sahley, 1999; Machekano, 1998, cited in Solomon et al, 2004) investigating this question, where it became apparent that males who reported recent casual partners, i.e. indicative of a high perception of risk, were more reluctant to learn their HIV status. This is possibly attributed to avoidance coping.

*2.8.5 Lack of Perceived Benefits*

A lack of perceived treatment benefits- the result of ARV roll out occurring at such a slow pace in South Africa (Kalichman et al; Van Dyk et al; 2001; Flowers et al, 2003: 745 & Ford et al, 2004: 493) act as another deterrent to HIV testing. Slow rollout of treatment in developing countries is exacerbated by its costs and lack of infrastructure required administering these drugs (Day et al, 2001). Some individuals furthermore do not perceive the treatment to be effective and beneficial, thus holding a very pessimistic outlook (Flowers, 2003: 745; Ford et al, 2004: 494). Day et al (2001) found that 65% of mine workers in their study ‘thought that no drug could improve the health of a person living with AIDS; and increased availability of ARV’s did not translate into increased willingness among workers to go for testing.

*2.8.6 Gender Differences in HIV Test Acceptance*

A few differences in the motivations behind testing for males and females are evident from the literature. In a study conducted in the Eastern Cape (Hutchinson, 2005) males tested more than females. Gender differences in the determinants of VCT utilization in this study included males being more orientated towards convenience and the resulting ease of access. Increased test acceptance occurred among males when rapid testing was used; when they were visited at home for palliative care; and when they lived close to the

testing site. Women, as previously mentioned, were more concerned about stigma and partner violence as a consequence of a positive result.

Factors classified as barriers to test acceptance frequently associated with males include a lower perception of risk to HIV infection than women (Kellerman, Lehman, Lansky, Stevens, Hecht, Bindman & Wortley, 2002; Downing et al, 2001; Stein et al, 2000). Some studies have found (Solomon et al, 2004) that in instances where males do test it is to confirm that they are HIV negative; while women are aware of personal susceptibility and therefore engage in HIV testing to find out if they are HIV positive.

Low perception of risk, as previously mentioned, often results in low or infrequent utilization of health care services by males (Marcell, Raine & Eyre, 2003), especially amongst those in their late adolescence. This further reduces opportunities for testing. Earlier the reproductive health scene was primarily focused on women. Hence, males might not feel very welcome in these female orientated settings; or they might shift the responsibility to maintain sexual health automatically to their female partners.

Health care providers resultantly lack adequate training to interact with male clients and often feel uncomfortable when engaging with them, the result of scant attention paid to male's health. It has been shown that male practitioners are less likely than female practitioners to assess their client's sexual risk, or to enquire about condom use (Mooki, 2003). Young men are simultaneously hesitant to enquire about their sexual health and view it as "naiveté and failure" (Mooki, 2003). The ability to effectively communicate and to put the client at ease is frequently mentioned as a crucial prerequisite for a fruitful VCT session; fostering trust, co-operation and compliance from the client.

While women are more concerned about the threat of violence, men are increasingly concerned about their image. In a study conducted by Day et al (2001) mineworkers living in hostels regarded status in their group as very important and the possibility of their role and reputation within this environment being tainted with a positive HIV test result was an overriding fear.

*2.8.7 Accessibility of VCT*

Certain communities, formerly neglected such as rural areas, still do not have adequate access to VCT service centers (Solomon et al, 2004). Costs related to testing and treatment services (Urassa et al, 2005: 847: Hutchinson et al, 2002: 108 & Spielberg et al, 2003: 322); and inconvenience caused by long waiting periods for test results, or distance with regard to testing site location (Downing et al, 2001: 573; Flowers et al, 2003: 745; Ginwalla et al, 2002: 713; Ford et al, 2004: 493 & Hutchinson et al, 2002: 108) are in the majority of cases associated with low, or no test acceptance.

*2.8.8 Organizational Factors*

The quality of VCT services is often compromised due to its high demand (Solomon et al, 2004). Sites mostly lack necessary resources such as staff members, testing kits, finances, infrastructure or basic medication. Those managing and administering VCT often do not have the relevant skills to execute the task. VCT counselor morale impacts on the quality of services. Sometimes counselors, e.g. in the case of nurse counselors, perform multiple tasks and struggle to define their duties. There are no clear boundaries and the results are often frustration and burnout. Sometimes no systems exist to monitor the quality of the service rendered, making service improvements almost impossible.

A great number of South Africans remain suspicious of the heath care system not trusting health workers to keep information confidential. A lack of privacy and confidentiality is often associated with the public health sector. They also fear prejudice by health workers after testing HIV positive (Ginwalla et al; Van Dyk et al; Downing et al, 2001: 572; Flowers, 2003: 745; Marcell et al, 2003: 184; Urassa et al, 2005: 849; Ford et al, 2004: 494; Fylkesnes & Siziya, 1999: 569 & Sauka & Lie, 1997). Negative attitudes of staff members toward those seeking care might further prohibit people from testing.

*2.8.9 Inconsistent HIV Messages*

Discordant or confusing messages around HIV/AIDS; especially from prominent leaders creates uncertainty and undoubtedly contributes to VCT resistance (Strode et al). In a

study conducted by Van Dyk et al (2001) some of the respondents indicated that uncertainty and insufficient knowledge about the virus might result in people acting on myths such as raping babies. Hence, some participants do not always deem it wise for people to know their HIV status.

*2.8.10 Interpersonal and Cultural factors*

A false sense of security due to a partner testing HIV negative (Downing et al, 2001: 571); lack of effective communication regarding reproductive health issues amongst couples; and a lack of support within relationships (Ford et al, 2004: 493 & Gage et al, 2005: 162) might also deter test seeking. In some instances people might be motivated to test by the need to protect significant others. In other instances people are expected to undergo VCT as a request from a partner when entering into a new relationship, or pursuing a marriage commitment. Solomon et al (2004) are of the opinion that individuals also access VCT to determine their status with the purpose of ceasing condom use within the relationship. Most people prefer the services of the "Sangoma", or "Nyanga" to the local VCT clinic (Solomon et al, 2004).

*2.8.11 Reasons behind Test Acceptance and Refusal*

Those individuals who do however test frequently site wanting to know one's HIV status; applying for insurance; being pregnant; feeling ill (HSRC, MRC & CADRE, 2005; Day et al, 2001); and taking preventative measures as primary reasons for testing. In another study (Van Dyk et al, 2001) when participants were asked why they think people should know their status, prevention of HIV transmission; gaining access to treatment; enhancing surveillance and awareness programmes; and preparing for death, or a will for the future were frequently mentioned.

In a study conducted by Day et al (2001) among mine workers in South Africa participants were asked why people fail to test for HIV. Fear of being HIV positive, and fear of other people's reactions, as well as a fear of death were the most frequently mentioned reasons. Van Dyk et al found (2001) found that 66.7% of South African study participants were of the opinion that it is not advisable for every person to know their

HIV status since knowledge of HIV status exacerbates depression culminating in early death. They also referred to the limited treatment options available and the fact that some people are not adequately trained to care for themselves, or others infected with HIV as reasons behind test avoidance.

Attention now shifts to the methodology employed in the search of those factors that motivate and prevent males from accessing VCT.

# CHAPTER 3

# METHODOLOGY

## *3.1 Participant Recruitment*

Data was collected in September 2006 from males who are members of two rugby clubs- Gardens and Progress based in Uitenhage, Eastern Cape. These clubs were chosen since they provide easy access to males resident in certain neighbourhoods in Uitenhage served primarily by the Rosedale Public Health Clinic. These neighbourhoods are Rosedale, Taambo, Gamble and Mountain View. The Rosedale clinic was chosen since it hosts an integrated model of VCT; i.e. both VCT and routine testing to primarily pregnant women are administered there. The testing site was started in 2000. It is found that males access VCT to a lesser extent than females at the clinic[7].

## *3.2 Participation*

Club members were informed of the research in August 2006 during meetings and practice sessions and membership lists were obtained from the management of each individual club after they provided permission for the research to be conducted. Males were deemed eligible for participation in the study if they fell within the age range of 18 to 25 years at the time of the study. Individuals falling within this age category are generally deemed highly sexually active and thus more vulnerable to HIV infection.

## *3.3 Participant rights*

The researcher contacted each selected player, either telephonically or personally at their homes in instances where contact numbers were not available on the list. A thorough explanation was given to all potential participants of the research purpose and what their rights as potential study participants are. These include the right to confidentiality; privacy; anonymity and the right to an informed individual choice in the absence of coercion. Participants were given the opportunity to pose questions in instances of uncertainty. Participants signed the study consent form as prove of informed consent and voluntary acceptance of participation.

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[7] VCT figures obtained from a trained counselor at the clinic

*3.4 Sample description*

The names of all the players falling within the selected age category, 18-25 years, were extracted from membership lists for both clubs. The researcher finally compiled a single list containing all the players falling within the designated age category. The sample was drawn proportionate to the size of each club, selecting 18 players from Gardens and seven from Progress. Hence, there were 25 players initially selected but only 18 players, 14 (78%) from Gardens and four (57%) from Progress, accepted participation in the study. Players were selected for inclusion into the sample selecting a random number, and thereafter selecting every third consecutive player.

*3.5 Refusal Rates*

Seven participants (28%) rejected participation in the study. It included four players from Gardens and three from Progress. Reasons provided for refusal included not having time to participate due to demanding work shifts. Two participants had no particular reason for refusal. Another two participants who initially agreed to participate changed their minds; the one feeling ill on the day that the interview was scheduled for. The other one evaded the interview without any excuse.



*3.6 Data-collection Instrument*

Participation in the study translated into completion of a semi-structured, face to face interview conducted by the researcher. The questionnaire contained both open ended- and closed questions. Each question included in the questionnaire was based on previous research and empirical observations made by the researcher. The questionnaire aimed to establish:

- How testers and non-testers compare in terms of socio-demographic characteristics;
- Participant's awareness and understanding of VCT;
- Tester's experience of VCT in order to establish motivators of VCT acceptance;
- Barriers to VCT acceptance; and

- The prevalence of perceived stigma and stigmatizing attitudes among testers and non-testers and how it influence test acceptance.

This mode of observation was chosen because it gives males the opportunity to give their own perspective or opinion on reproductive issues; predominantly regarded as a female domain. It further allows for new, untapped areas to emerge from discussions with males. All interviews were conducted in the participant's home language, Afrikaans, and responses were later translated into English. The duration of the interview ranged from 30 minutes to 60 minutes dependant on the length and breadth of participant responses.

After completion of fieldwork, the researcher conducted follow-up telephonic interviews with available participants to further probe two areas of interest elicited through the face-to-face interviews. These areas are joking about HIV related matters and participant's definition of behaviour increasing their risk of HIV infection. Thirteen (72%) of the initial 18 participants kindly accepted telephonic interviewing. Eleven players from Gardens (79%) and two from Progress (50%) participated. The remaining five participants could not be reached.

The researcher finally conducted a focus group discussion with four male graduates recruited at a graduate development programme. This was done to determine how their responses coincide with, and/or differs from the line of responses generated through face-to-face interviews. It is also considered a valuable method in generating areas that did not emerge from face to face interviews conducted with rugby players. These males were also briefed on the study purpose and their rights as participants.

*3.7 Pilot testing of Questionnaires*

The questionnaire was pilot-tested on six randomly selected participants. Pilot participants made the following comments:

- Some of the questions sound repetitive.
- Some questions are unclear and cause confusion.
- One pilot participant deemed the questionnaire time-consuming, while another said that it is too short.

- The question on the probability of the participant testing positive for HIV caused discomfort for some participants. The researcher decided to keep this question since it provides insight into participant's perception of risk; cited in the literature as a crucial determinant of VCT acceptance among males.
- One participant suggested that more educational questions on VCT could have been posed.

Adjustments were made according to the comments raised relevant to the purpose of this study.

*3.8 Data Analysis*

A content analysis of recurring themes was done manually since there were only a small number of participants. This method is however very time-consuming and more susceptible to human error. Results were double checked to minimize the occurrence of error. The focus group discussion was conducted in English. It was tape-recorded and transcribed for purposes of content analysis.

*3.9 Limitations of the study*

A possible limitation of the study might be the fact that a female researcher conducted interviews. Although males appeared comfortable during interviews; the possibility of them under reporting, exaggerating and distorting certain aspects to avoid embarrassment or to 'safe face', cannot be ignored. The majority of interviews were conducted at participant's homes and, in limited instances privacy was not always guaranteed. In those instances participants felt uncomfortable and were more likely to give limited responses.

# CHAPTER 4

## EMPIRICAL CONTEXT OF THE STUDY[8]

The study was conducted in Uitenhage with males from Rosedale, Gamble, and Taambo. These are all neighbourhoods in Uitenhage. Uitenhage is situated in the Eastern Cape and is located within the Nelson Mandela Bay Metropolitan Municipality (NMBMM) district. The geographical area of the NMBMM is 1950 square kilometers. The total population of NMBMM is 1005 778. The total population of Uitenhage is 413 283 and it accounts for 41% of the total population of NMBMM. Females and males constitute 52% and 48% of the total population respectively. Black people constitute 78%; Coloureds 15%, and Whites 7% of Uitenhage's total population[9] Youth from the ages 15-34 years represent 37% of NMBMM's total population. Males account for 49% and females 51% of this age group respectively.

The highest level of education obtained by the majority of individuals, 20 years and above, in NMBMM is some secondary education. Twenty four percent of individuals have obtained grade 12 (senior certificate); while only 9% have higher education. The unemployment rate in the NMBMM is 46%. The median annual income of working adults aged 15-65 is R21 837.

The HIV positive seroprevalence among pregnant women in NMBMM is 34.5%; greater than that on a provincial (28%), and a national level (29.5%). There are 41 permanent clinics in NMBMM and 14 mobile clinics. Two clinics have been upgraded and 6 new ones built. The nurse vacancy rate within NMBMM is 42%. Antiretroviral medicines (ARV's) are been administered in 3 hospitals; 5 municipal clinics and 4 provincial clinics within the bay.

[8] Information based on census 2001 and extracted from: www. statssa. gov.za and NMBMM Integrated Development Planning Document.
[9] Figures obtained from the Uitenhage Municipality

The Rosedale clinic presents one of the sites where VCT has been administered since 2000. The clinic started its ARV site in 2004. Its total client population was 41 907 in 2004.[10] Females and males from 18 to 24 years account for 7.2% and 6.9 % respectively of the total population. The number of HIV positive adults seen at the clinic within the first six months of 2006 totals 2063. Males constitute 627 (30%) and females 1436 (70%) of HIV positive clients at the clinic. Figures for HIV positive clients seen in the first six months of the current year at some clinics and hospitals in the NMBMM are as follows:

- Kwazakhele clinic: Males 1708 (28%) and females 4444 (72%);
- Laetitia Bam clinic: Males 1013 (29%) and females 2540 (71%);
- Livingstone Hospital: Males 632 (38%) and females 1046 (62%);
- Masakhane clinic: Males 501 (31%) and females 1137 (69%);
- Motherwell: Males 868 (26%) and females (74%); and
- New Brighton: Males 1242 (30%) and females 2870 (70%)

Within the first six months of 2006, 190 HIV infected males (30%) benefited from the ARV readiness programme at the Rosedale clinic. These are all males with a CD4 count below 200 per cubic milliliter of blood. The estimated number of clients voluntarily accessing HIV testing (VCT) at the Rosedale clinic on a weekly basis is plus/minus 50 of which 60% is female and 40% males. Those coming on a monthly basis is estimated at 185; and 57% of these clients are female and the remaining 43% are male.

VCT at the Rosedale clinic is administered on a daily basis. Rapid testing is used. There are currently four VCT counselors at the clinic; all of which are female. Two counselors are black, and the remaining two are Coloured. Two of the counselors are HIV positive. Each counselor receives a stipend of R600 per month. Their duties include administering ongoing counseling to HIV positive clients; doing home-based care; assisting clients in applying for social grants and funeral societies; and delivering educational talks. Some of them provide intensive spiritual and emotional support to HIV positive clients.

[10] Obtained from Nelson Mandela PHC-OrgUnit5 Population Mid-year Estimates, 2004.

# CHAPTER 5

# FINDINGS

## 5.1 SOCIO-ECONOMIC DESCRIPTION OF PARTICIPANTS

### *5.1.1 Participants in face-to-face interviews (Rugby players)*

The majority of participants, sixteen (89%), classifies themselves as Coloured. The remaining two classify themselves as Black. All participants were single at the time of the study. Thirteen participants (72%) stay in Rosedale, two (11%) in Gamble, another two in Mountain View, and the remaining one is resident in Taambo. Nine participants (50%) hold a senior certificate (matric) only, while the remaining nine have some tertiary qualification. Ten participants (56%) are unemployed; two of these are currently university level students and one is a matric learner. The primary means of income is pocket money from parents sited by the majority of unemployed participants. All of the employed participants, eight, support other people financially. Three participants have one dependant only; another three have three dependants; and one participant has up to five dependants. The remaining one participant has 2 dependants. Eight participants (44%) pay cash for medical services; another eight, primarily those employed, have access to medical aid. Two participants make use of state funded medical services. The majority of participants, seventeen (94%), stated that they only access medical services when it is really necessary. One participant goes on a monthly basis. Table 1 indicates how the different age groups from 18 to 25 years are represented in this study. The mean age of all participants is 21 years.

Table1 - Age distribution

| **Age (years)** | **Number of participants** |
|---|---|
| 18 | 2 (11%) |
| 19 | 0 |
| 20 | 4 (22%) |
| 21 | 4 (22%) |
| 22 | 2 (11%) |
| 23 | 4 (22%) |
| 24 | 1 (6%) |
| 25 | 1 (6%) |
| Total | 18 (100%) |

*5.1.2 Participants from focus group discussion (Graduates)*

All four males classify themselves as Black. One participant is 23 years of age; one other is 24 years; one other is 25 years and the remaining one is 28 years. The mean age is 25 years. The latter participant does not qualify to participate in the study since he is older than the designated age category (18-25 years). He was nevertheless included due to his willingness to participate. Participants are all single and currently unemployed. The highest level of education obtained by each participant is at the tertiary level. Two of the participants are from KwaNobuhle, a township situated in Uitenhage, and the remaining two live in Motherwell, Port Elizabeth. Three participants pay cash for medical services and the remaining one makes use of state funded services. Similar to the rugby players, three of the graduates only access services when the need arises, while the remaining one goes annually.

## 5.2 KNOWLEDGE OF VCT

### *5.2.1 VCT Awareness*

Thirteen of the eighteen rugby players (72%) stated that they have previously heard of VCT. The remaining five (28%) have never heard of VCT before. Graduates participating in the focus group discussion all stated that they have previously heard of VCT. Table 2 illustrates the sources of VCT information cited frequently by rugby players and graduates:

Table 2- Frequency of VCT sources

| **Source** | **Frequency (Times sited)** |
|---|---|
| Media | 14 |
| Word of mouth | 10 |
| School | 6 |
| Clinic | 4 |
| Work | 3 |
| Books | 2 |
| Church | 2 |
| Total | 41 times |

### *5.2.2 Participant Understanding of VCT*

Participants, both rugby players and graduates (22 in total) were asked what their understanding of VCT is; i.e. what its most important components entail. Out of the 22 respondents, only five respondents (23%) were able to give a complete explanation of all three VCT components; i.e. its voluntary nature, counseling procedures and testing. Three of these were focus group participants. Eleven respondents (50%) were able two give explanations of at least two of the three VCT components. Eight rugby players (67%) not previously tested mentioned these explanations, in comparison to only two previously tested players (33%). One of the focus group participants completed 1-2

component explanations. Five respondents, all rugby players, provided vague or unrelated explanations. One of the rugby players, not previously tested, has no clue of what VCT means or entails.

## 5.3 PERCEPTION OF RISK OF HIV INFECTION AMONG RUGBY PLAYERS

The majority of participants, fifteen (83%) stated that their chances of testing HIV positive, should they go for an HIV test, are low to very low. The remaining three participants (17%) said they have a medium chance to test HIV positive. None of the participants perceived themselves to be at high risk of HIV infection.

Reasons frequently cited for these low to very low risk perceptions, mentioned from highest to lowest frequency, include having sex with only one partner (cited 5 times). Reasons cited three times individually are practicing sex with a condom at all times; no previous contact with blood; and previously tested for HIV (knowing my status). Other reasons cited only once include abstinence, certainty of status in the absence of an HIV test and, the absence of symptoms hinting at possible HIV infection, i.e. not feeling ill. Those two participants perceiving their chances to be medium for HIV infection frequently cited incidences of unprotected sex (cited by both participants), no previous HIV testing (1), and no recent test (1) as motivations behind their perception. The participant referring to no recent test stated that anything could have happened in the meantime that might have put him at risk.

## 5.4 DEFINITIONS OF HIGH-RISK BEHAVIOUR ACCORDING TO RUGBY PLAYERS

Check backs were done telephonically and telephone interviewees (13) were asked what, according to them, constitutes high-risk behaviour. Responses, in descending frequency are:

- Abuse of alcohol and drugs at parties leading to unprotected sexual intercourse (sited 6 times);
- Unprotected sex with an HIV infected person (4 times);
- Making contact with somebody else's blood (3 times);

- Sharing the same needles for tattoos (1);
- Fighting and robberies (1);
- One respondent did not know what constitutes high-risk behaviour.

## 5.5 HIV TESTING PROFILE OF RUGBY PLAYERS

### *5.5.1 Testing Rates*

Twelve of the eighteen participants (67%) have never tested for HIV. Of those who tested 6 (33%), only one person went for HIV testing more than ones. Four of the participants went as recently as 2005 and 2006 for HIV testing. The dates for the remaining two are not known. Only one of the focus group participants previously tested for HIV.

### *5.5.2 Reasons for HIV Testing*

In 3 cases, application for insurance was the main enabler of HIV testing; followed by the need to know one's HIV status, cited twice. One incident of unprotected sex motivated another participant to go for HIV testing. Another participant viewed testing as an indication of what to expect in future. The same participant was further motivated by the need to protect his girlfriend from HIV infection due to the possibility of negligence on his behalf. A risk factor to him is the fact that he is involved in contact sport and, there was an incidence where he was bitten during one of the matches. Another participant further views HIV testing as a way of boosting confidence levels. Finally, one participant tested as part of a package of services when going for a routine medical check-up and therefore indicated that he had no particular reason for accessing testing.

In the focus group discussion it became apparent that male's motivation to test is sometimes influenced by the nature of the relationship that they are involved in and, their health status. Two of the graduates would consider testing once they are in serious relationships, moving towards marriage. Two of the rugby players held the same view:

*Graduate no 2: "I am a church goer and if I'm serious with a girl, and I plan on marrying her than I would consider HIV testing…"*

*Graduate no 3: "I think it's sometimes pressure from your partner. Let's say you meet a new partner and obviously she's going to ask you are you* [HIV] *negative or positive. If you're really serious with that partner you'll probably go for testing…"*

*Rugby player no 2: "I would definitely consider testing before marriage or when I meet a girl whom I'm serious with…"*

*Rugby player no 7: "At this stage I can't say if I would go for testing* [in the following 3-6 months] *but it depends on meeting a girl that I'm serious with; only then would I consider testing…"*

Another graduate asserts that males are often motivated by the appearance of physical symptoms to go for HIV testing:

*Graduate no 4: "Others will wait till they see or feel that there's something wrong with them; they won't go* [for testing] *if they still feel fit and healthy…"*

*5.5.3 VCT Sites Used*

Two of the participants accessed testing at work. One of them went during a VCT awareness campaign held at work. Other sites mentioned by the remaining four participants include the university campus during an awareness campaign; the public hospital; public clinic, and the private clinic. Reasons for testing at these specific venues include the fact that it was the closest site and VCT was readily available, cited three times. Another participant referred to the fact that counselors at the university VCT campaign made testing worthwhile. One person went for testing to that specific public clinic because nobody knows him there. Another participant accessed testing at the private clinic because the life insurance company recommended it where he applied for insurance. The participant who received HIV testing at the public hospital was routinely offered HIV testing as part of a routine medical check-up.

*5.5.4 Reasons against Testing at Rosedale Clinic*

All those who have previously tested stay relatively close to the Rosedale Dental (public health) Clinic where VCT is available since 2000. They were asked why they did not make use of VCT services rendered at the clinic. These were their responses:

- There are too many familiar faces at the clinic and, by implication people might gossip and speculate (sited 4 times);
- They might make mistakes because they help too many people in a short time (2);
- Service delivery occurs at a very slow pace (1);
- Too many people are infected with HIV in Rosedale and people might become suspicious once they see me there (1); and
- I don't trust staff members at the clinic (1).

Participants not previously tested for HIV made voluntary comments about the Rosedale clinic. One participant also referred to slow service delivery at the clinic; and another to the persisting presence of student nurses at the clinic. The latter participant is questioning the competence of these nurses and states that they are more likely to make mistakes then experienced nurses. Two participants referred to cleanliness at the clinic and perceive the clinic as untidy. One of them is not willing to access services at the clinic as a result of this.

*5.5.5 Levels of Satisfaction with HIV Testing Services*

Three of those who have previously tested received both pre- and post-test counseling, while the remaining three did not receive any form of counseling. Two of those who did not receive counseling tested as prerequisite for an insurance policy, individually at work and at a private clinic. The other one tested at the Uitenhage Provincial Hospital. None of the participants were able to provide reasons for this lack of counseling. An increased likelihood of receiving counseling in this study is associated with testing as part of awareness campaigns or at a public clinic. Participants were very satisfied with the venue where counseling and testing took place and they considered it as private (sited by all six participants) and appropriate for its purposes.

Words used by participants to describe counselors and/or nurses who administered VCT to them are "friendly" (3); "knows her stuff", i.e. competent (2); "professional" (2);

"trustworthy" (1); "accommodative" (1); "knowledgeable" (1); "supportive" (1); "positive attitude" (1); and "not in a hurry" (1).

Four of the participants waited between 1 and 3 weeks for their test results (taking cognizance of the fact that one participant went for testing more than once); and three received their results on the same day. The majority of the participants 5(83%) preferred receiving results on the same day. Only one participant preferred waiting one week for his results since it allowed him more time for preparation. Those in favour of same-day results said that longer waiting periods exacerbate stress and worries, while rapid testing allows you to immediately know where you stand.

*5.5.6 Tester's Willingness to inform others of HIV Testing*

Four (67%) of those previously tested for HIV told somebody that they have gone for HIV testing. Two of them chose not to tell anyone. Two of the participants disclosed because they felt motivated to do so. The remaining two individually told others as an indication of future plans, and because of the need to "unload". Participants mainly chose to tell either friends (3) or girlfriends (2). One person avoided telling others for fear of them becoming suspicious; and the other just felt like keeping it to private.



The majority of testers, 5 (83%) were willing to encourage others to go for HIV testing. Reasons include the importance of knowing your HIV status (3), especially individuals at high risk for infection (1); and that testing will lead to a safer environment (1). One person would not encourage others if the waiting period for test results were longer than a day.

*5.5.7 Reasons why Males Resist HIV testing*

*Fear*

Fear, cited 6 times (50%) by rugby interviewees not tested for HIV, appeared to be the main reason why the majority of males resist HIV testing. This fear is psychological in nature and is generated when people anticipate all the negative consequences of a positive result. Most of the participants have a very fatalistic outlook, and stated that they

would not be able to cope with a positive result; they would literally fade away. One of the respondents even anticipates suicide should he tests HIV positive in future. This finding is echoed in the focus group discussion:

*Graduate no 4: "It's a psychological depression; you wake up and think about the same thing over and over again and eventually you die…"*

*Graduate no 2: "…you think it's the end of the world; that it's a guarantee that you'll die…"*

*Graduate no 3: "It's a fear of knowing that you're going to die when they say you're HIV positive. It's always on your mind- I'm going to die! So, you die before your time. Mentally you are already dead; you die mentally before you die physically…"*

*Graduate no 1: "It's a fear of suffering…a physical and emotional suffering…"*

One of the graduates referred to the fear of blame and possible rejection especially by family members:

*Graduate no 4: "…you fear the reaction of your family because they're gonna say that you were careless since you know about HIV/AIDS…"*

Continuous reference to other people's reactions when they find out that an individual is HIV positive was made. These reactions sometimes involve violence:

*Graduate no 4: "…if you go for the test and your test is HIV positive, people are going to pass negative remarks at you…"*

*Graduate no 3: "…people will gossip about you; if they see you in town they'll make fun of you and talk about you behind your back…"*

*Graduate no 4: "…I've had a friend who was infected with HIV by his girlfriend. As a result, he ended up killing his girlfriend because she was HIV positive. In another incident the guy burnt his girlfriend…"*

*No High Risk Behaviour or Low Perception of Risk*

Another reason, frequently cited (4 times) by rugby interviewees, include not practicing high-risk behaviour as reason why they are not yet tested. No high-risk behaviour is associated with the use of condoms at all times during sexual intercourse. Two people

made reference to the fact that they only have sex with one partner. Only one person abstains from sexual relations. Hence, they do not see the need to go for HIV testing.

*Testing not considered a priority*

One non-tester stated that testing was never a thought on his mind; he never previously considered it. Another rugby player expressed something similar during the telephonic interview, as well as some of the focus group participants:

*Graduate no 3: "…I don't see why because, really, we* [men] *don't see the need to go for HIV testing...basically we don't see it as a need; it's not a priority…"*

*Graduate no 2: "There's an I- don't- care attitude…"*

*Rugby player no 18: "…Ek sal persoonlik nie 'n voorstel maak om met die ouens te toets vir HIV nie want ons vat nie sulke dinge ernstig op nie, en hulle sal joke daaroor."*

*"I will personally never suggest to the guys that we go for HIV testing because we don't take such things seriously; they'll end up making jokes."*

*Testing and Teasing*

Males, both rugby players and graduates, often feared being the object of ridicule once they declare that they are going for an HIV test or, when they suggest group testing. They often prefer telling their friends about their test only if the result is negative. This is done to prove a point, or it is seen as something you can be proud of.

When asked what possible disadvantages of VCT are, one of the rugby players responded:

*Rugby player no 5: "Vriende gaan gekskeer…"*

*Rugby player no 5: "Friends are going to tease me…"*

Another respondent provided this as a reason why he has not yet accessed VCT. Elsewhere another respondent stated:

*Rugby player no 4: "…daar word baie jokes gemaak onder die manne en niemand praat rêrig daaroor* [HIV] *nie…"*

*Rugby player no 4: "…a lot of jokes are made about it* [HIV] *among the boys and we rarely talk about it…"*

When asked if they would suggest group VCT to 'the boys', two of the rugby players, from each individual club responded:

*Rugby player no 19: "Die ouens sal jou uitlag as jy met sulke suggestions kom…"*

*Rugby player no 19: "The boys will laugh at you when you come with these suggestions…"*

*Rugby player no 2: "Ek sal slegs die ouens vertel om vir HIV testing te gaan as ek gegaan het vir die toets en die results is negatief. Hulle gaan my terg as ek gaan; hulle sal sê ek hou my 'n engel of hulle sal byvoorbeeld vra- Het jy miskien met 'n slegte meisie seks gehad?"*

*Rugby player no 2: "I will only tell the boys to go for HIV testing after I have gone for the test and the result is negative. They're going to make fun of me if they find out that I've gone for the test; they're going to say that I am pretending to be an angel, or they're going to ask me- Did you perhaps sleep with a promiscuous girl?"*

When asked how an individual can benefit from VCT, one of the rugby interviewees stated:

*Rugby player no 9: "As jy byvoorbeeld jou vriende vertel dat jy vir 'n toets gaan dan maak hulle al klaar hulle eie gevolgtrekkings oor die result. As jy gaan toets kan jy hulle verkeerd bewys…"*

*Rugby player no 9: "If, for example, you tell you're friends that you are going for an HIV test, they already make assumptions about the result. If you go and test, you can prove them wrong…"*

One of the focus group participants confirmed the reality of jokes:

*Graduate no 3: "I told my friends but they laughed… They laughed when it* [HIV] *seemed very far from us but when it became close to home, after our friend died of AIDS; we realized that HIV is a reality…"*

Two of the respondents referred to making jokes about HIV related issues as a defense mechanism against a virus that represents such a great threat.

*Rugby player no 5: "Die jokes is 'n male-ego thing. Net die wete dat jy vir 'n* [HIV] *toets gaan laat die ouens assume dat jy alreeds HIV positive is. Ek dink die ouens gebruik dit as 'n defense mechanism teen iets wat ons nie regtig verstaan nie."*

*Rugby player no 5: "Jokes are a male-ego thing. Just the thought that you are going for an HIV test makes most guys assume that you're already HIV positive. I think they use it as a defense mechanism against something not well understood."*

The majority of telephonic interviewees, 9 (69%), confirmed this finding and they stated that they are aware of jokes among teammates. The remaining 5 interviewees (31%) made it clear that this is not a phenomenon exclusive to rugby players, or males in general but it is a phenomenon common to society. One of the rugby players stated that he does not perceive his teammates as capable of making fun of HIV positive people.

*More Reasons…*

Other reasons why rugby players have not gone for HIV testing include a lack of time (cited twice), and uncertainty regarding the origins of HIV/AIDS (cited once).

Additional reasons why focus group participants think males avoid HIV testing include non-readiness, pride (cited once), stigma, and denial (what I don't know won't kill me). One respondent referred to flawed perceptions about HIV/AIDS as a possible reason why some men avoid HIV testing:

*Graduate no 4: "Some people say it's a perception, that we all have HIV; it must just be triggered by something…"*

Another graduate referred to the nature of post-test counseling as a possible barrier to HIV testing:

*Graduate no 3: "…during counseling they ask you all these personal and intimidating questions about how many sexual partners you had, etc. It upsets you when they ask you these questions and I think most people don't go there as a result of this…"*

*5.5.8 Future Testing Intentions*

The majority of those never tested, 11 (92%) said they would consider HIV testing within the next 3 to 6 months. Reasons sited by some of the non- tested participants for wanting to know their status in future include the importance of knowing your status; consideration of the risk involved in contact sport; the fact that condoms are not 100% safe; when the need arises; and meeting someone that you are serious with. One person,

unsure of his future testing intentions, similarly provided this latter reason. He stated that he would strongly consider testing once he meets someone he seriously like; someone he would consider for marriage. Similarly, in the focus group discussion two of the participants provided this same reason when they were asked about future testing intentions.

*5.5.9 Public vs. Private Sector Health Service Delivery*

Non- testers were asked where they would access VCT if they decide to do so in future. They could choose among a private doctor; private clinic; public clinic; and public hospital. They were also granted the opportunity to mention alternatives. Table 3 illustrates their preferences:

Table 3: Public vs. Private Sector Health Care

NOTE: Participants indicated more than one preference

| **VCT site** | **Number of participants** |
|---|---|
| Private doctor | 7 |
| Private clinic | 4 |
| Public clinic | 4 |
| Public hospital | 2 |
| Does not matter | 3 |
| Total | 20 |

The remaining three participants indicated that they do not have a specific preference and would access VCT wherever it is available.

The majority of participants, eleven (92%) choose to access VCT in the private sector in comparison to only 6 participants (50%) in favour of the public sector. A private doctor was chosen because confidentiality is insured (cited three times); there is more privacy (2); safety is guaranteed (2); and because the (Rosedale) public clinic is untidy.

Participants choosing a private clinic also associated it with increased confidentiality (2), no long waiting periods (1) and increased attention given to all clients (1). Another participant stated that he is used to making use of private sector health services.

Those participants in favour of accessing VCT services at public clinics referred to the fact that no costs are involved (2) and one participant stated that he is not ashamed of going there (1). One participant perceives the public hospital as faster in terms of service delivery than the public clinic in his area. Of participants who did not indicate a specific preference, one stated that he would go anywhere where service delivery is fast and where test results are rapidly available. Another one said that people gossip irrespective of public or private sector health and, that both private and public sector health has its advantages and disadvantages.

*5.5.10 Preferred Testing Site Characteristics*

Non-testers were asked what their expectations are of the site where they access VCT. Table 4 depicts the most frequently sited characteristics:

Table 4 - VCT Site Characteristics

| **VCT Site Characteristics** | **Number of times sited** |
|---|---|
| 1. The site must be neat and tidy | 6 |
| 2. Sufficient resources | 4 |
| 3. Friendly staff members | 4 |
| 4. Efficiency- e.g. no incidences where blood is swapped and results flawed | 3 |
| 5. Qualified and competent staff members | 2 |
| 6. Privacy | 2 |
| 7. Speedy service delivery | 1 |
| 8. Confidentiality | 1 |
| 9. Adequate support structures | 1 |
| Total | 24 |

*5.5.11 Preferred Counselor Characteristics*

Features cited by more than one non-tester to describe prospective counselors are the ability to communicate freely (4); friendliness (3); honesty, not withholding crucial information (2); the ability to make clients feel at ease (2); being male (2); being female (2); and supportive (2). Features cited only once are being a good listener; understanding; informative; open-minded; sensitive to client's needs; funny; competent; not in a rush; humble; and confident of his/her ability to do the job. One participant stated that the person must be dressed in a white jacket as proof that s/he is a registered doctor because he fears people posing as doctors and infecting people with the virus by injecting them with HIV infected blood.

*5.5.12 Perceived Advantages and Disadvantages of HIV Testing*

*Advantages*

Rugby players and graduates regard knowledge of status (cited nine times) as an important benefit of HIV testing. Participants equated knowledge of HIV status with certainty related to one's health outcomes. Participants frequently (cited seven times) made reference to one's ability to take the necessary precautions and to make appropriate life style changes based on the outcome of the result. Four participants mentioned the role of HIV testing in bringing peace of mind or psychological relief when testing HIV negative. Two participants stated that knowledge of HIV status enables the individual to protect others from acquiring the virus. Another two participants, not previously tested, hold that they would be more motivated to encourage others to go for testing after they have tested. The ability to live a full life (2) is perceived as another benefit of testing. Other advantages of HIV testing include the ability to better plan for the future (1); feeling proud after testing HIV negative (1); and discrediting other people's assumptions about your HIV status (1). One participant singled out pre-test counseling as beneficial in terms of its provision of advice, support, and care.

*Disadvantages*

The most frequently mentioned (cited nine times) disadvantage of HIV testing is being confronted with the possibility of testing HIV positive. Most participants mentioned not being able to cope with a positive result and the thought of the inevitable- death. They refer to confrontations with instantaneous and dramatic life changes and stigma as negative outcomes of knowing your status. Three participants are not in favour of long periods of waiting for test results since it contributes to mounting stress, worries and anxiety. One participant testing during a campus VCT awareness campaign said that he was even more stressed after the counselor informed him about the number of people who tested positive on campus. A graduate participating in the focus group discussion finds the questions asked during pre-test counseling offensive and intimidating. The same participant stated that knowledge of one's status might lead to "exploring"; meaning that HIV infected people might purposely spread the virus to unaware individuals. One of the rugby players mentioned teasing by friends as another downside to HIV testing; and another views his problems with allergies as the only disadvantage. He fears that any piece of equipment used during testing might cause an allergic reaction. One individual does not discern any disadvantages of HIV testing.



## 5.6 PERCEIVED STIGMA AND STIGMATIZING ATTITUDES

*5.6.1 Perceptions of Stigma within Communities*

The majority of testers (67%) were in favour of the statement: "People in my community do not talk to you if you are HIV positive". Half of non-testers are in favour of the statement, while the remaining half opposes it. Overall, the majority of participants, both testers and non-testers (56%), stood in agreement with the statement.

The majority of participants (61%) are not in favour of the statement: "People in my community do not be-friend those that are HIV positive". Half of testers were in favour of the statement, and the other half rejected it. The majority of non-testers (58%) rejected this statement.

All participants are in favour of the statement: “People in my community gossip about those who are HIV positive”. The majority of testers and non-testers (both 67%) strongly agree with this statement.

When given the statement: “People in my community are capable of violence toward HIV infected individuals” 67% of all participants are not in agreement with this statement. The majority of non-testers (83%) are against this statement. Half of the testers agree with this statement and one tester was not sure.

The majority of testers and non-testers (67%) oppose the statement: “It is a disgrace in my community if you test HIV positive”. Eight percent of non-testers strongly disagree with this statement.

The majority of participants (56%) are not supportive of the statement: “No one in my community talks about HIV/AIDS”. The majority of testers (67%) oppose the statement while 50% of non-testers are in favour and the remaining 50% against the statement.

*5.6.2 Perceptions of Family’s Attitude toward PWA’s*

The majority of participants (78%) are against the statement: “My family will not eat from the same plate as I if I test HIV positive”. 67% of Testers and 83% of non-testers oppose the statement. All testers and 92% of non-testers do not think that their families will disown them once they test HIV positive. One of the non-testers, however, agrees with the statement. In addition, 56% of all participants do not believe that their families are capable of keeping their status secret if they should test HIV positive especially non-testers (58%) as opposed to 50% of testers.

*5.6.3 Personal Stigmatizing Attitudes*

The majority of participants (83%) do not mind being seen by familiar people at an HIV testing site. One of the testers, however, strongly agrees that he would feel ashamed if someone familiar spots him at a testing site. 50% of Non-testers in comparison to 33% of

testers strongly disagree with the statement: I'll feel ashamed if someone sees me at an HIV testing site.

All testers and non-testers are not supportive of the statement: HIV positive people are dirty. 33% of Non-testers in comparison to 17% of testers selected 'strongly disagree' to better express their preference.

Most participants (72%) are willing to share a cup with someone that is HIV positive. More non-testers (75%) than testers (67%) contest the statement: I will never drink from the same cup as someone that is HIV positive. Similarly, more non- testers (33%) than testers (17%) strongly disagree with the statement.

The majority of participants (89%) reject the statement: HIV positive people deserve their illness and suffering. 83% of Testers and 92% of non-testers dispute the statement. Four participants (22%), three being testers, stated that this is dependent on how these individuals have acquired the virus. Babies, for example, are considered innocent victims as opposed to commercial sex workers (prostitutes).

Most participants (94%) are in favour of starting a friendship with someone that is HIV positive. Only one of the non-testers 'strongly disagrees' with the statement. Similarly, all participants are willing to hug someone that is HIV positive. The majority of participants (72%) selected 'agree' to express their view. All, except one tester, dispute the statement: HIV positive people really irritate me.

All participants reject the statement: I hate HIV positive people. 50% of Non-testers in comparison to 33% of testers selected 'strongly disagree' to express their view. The majority of participants (83%) do not think it is a shame if an individual is diagnosed with HIV. All testers and almost all of the non-testers (92%) dispute the view that HIV positive people should stay on an island.

A small majority of participants (56%) are willing to openly talk about their HIV status should they test HIV positive. The majority of non-testers (75%) are willing to disclose an HIV positive status, while 83% of all testers dispute the statement.

## 5.7 CHARACTERISTICS ASSOCIATED WITH TESTERS AND NON-TESTERS

### *5.7.1 Levels of Education*

The highest level of education obtained by the majority of testers (83%) is some tertiary level education, referring to university, college, or technikon. The lowest level of education among testers is a senior certificate; the qualification held by the majority of non-testers (67%). Four of the non-testers (33%) have some tertiary level education.

### *5.7.2 Employment and Income*

The majority of testers are employed (83%) as opposed to the majority of non-testers (67%) being unemployed. The majority of non-testers (75%) are financially dependent on their parents.

### *5.7.3 Access to Medical Services*

The majority of testers (67%) are on medical aid, whereas 50% of non-testers pay cash for medical services and two are dependant on state-subsidized services. The majority of participants, both testers and non-testers (94%) only access medical services when the need arises. Only one person, a tester, visits the doctor on a monthly basis.

# CHAPTER 6

# DISCUSSION OF FINDINGS

## *6.1 Absence of Counseling*

Three of the participants in this study did not receive any form of counseling during HIV testing. Counseling is a crucial element of VCT and its importance should never be underplayed since HIV/AIDS is an epidemic plagued with serious ramifications. A lack of counseling and insufficient or non-existent emotional support might push someone not capable of coping over the edge. Fear of facing the negative consequences of an HIV positive result was a frequently recurring theme in both face-to-face interviews and focus group discussions. Participants have a very fatalistic view and some do not have adequate coping skills to deal with the problem- most participants anticipating death. Reference was made to a mental death preceding the physical one. Another individual mentioned committing suicide, and the chances of that happening are exacerbated in the absence of counseling and follow-up. One of the focus group participants suggested continuous counseling as one of the ways to remedy psychological consequences of testing HIV positive.

People are more likely to adapt alternative ways of coping in the absence of counseling. One way of coping is by avoiding or denying the situation. It includes reverting to previous patterns of behaviour, e.g. risky sexual behaviour, or failure to access much needed treatment. Some people resort to the internalization of certain myths or flawed perceptions. One of the focus group participants stated that there are commonly held views in his community claiming that we are all actually HIV positive; it only needs to be triggered. Another focus group participant mentioned the disturbing occurrence of "exploring" as a consequence of testing HIV positive. He explains that "explore" means to consciously infect unaware partners for fear of dying alone. One of the critiques against VCT sited in Solomon et al (2004) holds that VCT is primarily aimed at meeting epidemiological demands, i.e. to identify those who are HIV positive; while the psychological well being of infected individuals are sometimes compromised and neglected.

*6.2 Low Perceptions of Risk*

The majority of participants in this study is not tested for HIV and simultaneously perceives their chances of testing HIV positive as very low. Low perception of risk among males is consistent with previous findings. Low or infrequent utilization of health care services by the majority of participants might be the result of low perception of risk. The concern arises when this low perception of risk is primarily premised on the practice of sex with only one partner. The majority of participants ascribe their minimal chances of contracting the virus to this phenomenon. The safety that these relationships provide is questionable since people are increasingly being infected with the virus even within the context of marriage.

Individuals should further be weary of accepting the act of testing in itself as a way of protecting themselves against HIV since three participants ascribe their low perception of risk to previous testing. It is also worrying to realize that some individual's low risk perception stems from the absence of physical symptoms hinting at possible HIV infection. Low perception of risk might be the result of denial or avoidance coping.

Six of those (46%) who responded to telephone interviews (13) define high-risk behaviour in terms of drug and alcohol abuse within the context of parties, and how it often results in unprotected sex. This seems to be a valid cause of concern among certain rugby players. This is not a reality exclusively common to rugby players but it is a familiar scenario to the majority of the youth. Low perceptions of risk persist despite the vulnerability of the youth to HIV infection.

*6.3 Exposure to Testing Opportunities*

Most testers were initially or originally motivated by personal or individual level factors to access testing. These include concerns of possible HIV infection after engaging in unprotected sex; the need to gain certainty regarding one's HIV status; the need to feel confident; and the need to protect others. In the majority of cases, five, these individuals were presented with the opportunity to access HIV testing. Two participants were

confronted with HIV testing by means of awareness campaigns held respectively at work, and on campus. Another two tested as requirement for an insurance policy and, one other participant was presented with the opportunity to test during a routine medical check- up. Only one participant pursued testing on his own by physically going to a public health clinic. The question remains as to whether other testers would have pursued testing on their own. In the majority of instances testing was made readily available to testers, and most of them indicated that they have enjoyed the ease of access. Two of the non-tested rugby participants and two focus group participants view serious relationships and marriage as opportunities required to be present in order to consider testing. Some might even view the manifestation of illness as an opportunity to go for testing.

*6.4 Perceptions of Public- and Private Sector Health care*

Testers and non-testers frequently equated public health service delivery with lower levels of privacy; reduced levels of confidentiality; and reduced levels of safety and sufficiency, i.e. they regard them as more prone to make mistakes when administering VCT due to large client volumes on a daily basis. They are not saying that public health staff is incompetent but they expressed concerns about the accuracy of certain techniques employed especially when staff is pressed for time as a result of a very demanding client base. One participant expressed concerns about the persistent presence of student nurses within the public health care setting. Participants also referred to the slow rate of service delivery within these settings and the limited amount of special attention that is given to each individual client since everything is rushed in order to assist the next client. Untidiness has also, in some instances, been associated with public sector health. The only positive aspect related to public sector health, emerging from face-to-face interviews, is the fact that services are cost free.

The majority of participants, on the contrary, view private sector health as synonymous with guaranteed privacy; confidentiality; safety; competence; cleanliness; speedy service delivery; and increased levels of individual attention. This is worrying since the majority of individuals does not have the luxury of increased options and are confronted with the public sector as their only resort. They should therefore not be discouraged from

accessing available services. Public sector health care professionals are under immense pressure due to mounting client volumes and a lack of vital resources. They attempt to give the best possible care under these circumstances. This should, however, not be used as an excuse to justify and perpetuate negative attitudes toward clients or to purposely compromise the quality of service delivery.

*6.5 Shifting Blame and Responsibility*

Concerns regarding violence toward women are confirmed in this study. One of the focus group participants autonomously referred to one of his friends killing his girlfriend after he found out that she infected him with the virus. He simultaneously referred to another woman that was burnt after her partner suspected her of infecting him. One other focus group participant expresses his views on this phenomenon:

*Graduate no 3:"I think no one knows where this virus comes from but, the main thing that I've experienced is that in most cases men blame women for spreading the virus because they say they* (women) *do sleep around…"*

The remaining focus group participants stated that men should assume responsibility for their own behaviour:

*Graduate no 1: "I will say, personally, I won't judge women because even men can sleep around…"*

*Graduate no 2: "I agree with no 1; men do spread AIDS widely because they want second girlfriends…"*

There is no time for men and women to blame each other for the transmission of the virus. Both parties should assume responsibility and work alongside each other to conquer the devastating effects of HIV. This notion of men blaming women might further perpetuate the belief that women are solely responsible for the maintenance of reproductive health. Men might therefore exempt themselves from actively taking steps to ensure that both they and their partners are safe. Active male involvement and support might set the stage for more women to disclose their status to their partners without anticipating a violent response.

It is worrying when some males do not perceive HIV testing as a priority as indicated by both interview and focus group participants. These refer to those males who do not perceive HIV testing as something demanding immediate attention; those reserving the test for a serious relationship or marriage. Frequent reference has also been made to males teasing each other about HIV/AIDS and related issues such as HIV testing in an attempt to deal with something that everybody grapples to come to terms with. Males are motivated to encourage others to go for HIV testing only when the result is negative. Testing is used as validation of an HIV negative status. This finding coincides with previous research stating that men are more concerned about maintaining an untainted image among their peers. It poses a problem since this notion of negative-only disclosures places immense pressure on those who do in fact test positive to keep quiet about it for fear of the group's reaction to it. They might engage in denial and avoidance coping; jeopardizing their own health and that of others such as team mates and sexual partners. Some men might even avoid HIV testing due to fear of being mocked by friends.

*6.6 VCT-related Advantages and Disadvantages*

The majority of participants perceived numerous benefits linked to HIV testing. The nature of these benefits was related to physical and psychological well being and to interpersonal factors such as the ability to protect others. No mention was made of medicinal treatment related benefits.

The most pervasive disadvantage of VCT, as expressed by testers and non-testers, is the stress and anxiety caused by anticipating all the negative consequences of a positive result. Some participants have also expressed their dislike of long waiting periods for test results since it contributes to already heightened stress levels. One focus group participant voiced his concerns about the intimidating nature of questions posed during pre-test counseling. Criticism of VCT (Solomon et al, 2004) include questions regarding the culturally appropriateness of the counseling model for developing countries. The counseling model on which VCT is premised is often criticized as Western, individualistic and bio-medical; and its efficacy in collective societies such as South

Africa is always under scrutiny. One participant referred to an incident where the counselor evoked so much fear in him after informing him of the numbers of people who have tested positive during the awareness campaign. These inputs should be eliminated from the counseling discourse since it also amplifies the stress experienced by clients.

*6.7 Perceived and Personal Stigma*

Testers in this study appear to discern or perceive more hostility in their communities toward people with AIDS (PWA's) than non-testers. In general, both testers and non-testers perceive their families as accepting toward PWA's. With regards to personal stigmatizing attitudes, non-testers once again appear more accepting of PWA's than testers, although participants in general are not dominated and controlled by destructive attitudes toward PWA's. Four testers perceived the mode of HIV transmission as a determining factor in deciding whether an individual deserves his illness and suffering or not. The majority of non-testers (75%) are willing to talk openly about their HIV status should they test positive; whereas 83% of testers oppose this. Only a few participants show some degree of hostility toward PWA's. One non-tester is strongly against starting a friendship with someone who is HIV positive; three participants (one tester and two non-testers) agree that it is a disgrace to be diagnosed with HIV; and one non-tester agrees that HIV positive people should be isolated on an island.

Former studies have associated no to low levels of stigmatizing attitudes toward (PWA's) with an increased likelihood of HIV testing; and that those not tested for HIV are likely to show greater disapproval of PWA's (Kalichman et al, 2003). The opposite was found in this study. This might indicate that people are becoming more sensitized toward PWA's, creating an environment more conducive to HIV testing.

The majority of non-testers have indicated that their families will not be capable of keeping their HIV result a secret should they test HIV positive. Premature or inappropriate disclosure of someone's HIV status without his knowledge or consent can have negative consequences on the individual. The decision remains with the individual

whether he wants to disclose his HIV status or not. Fear of inappropriate disclosure might further pose as a barrier to HIV testing; or it might reinforce avoidance coping or denial.

### *6.8 Participant Characteristics Associated with Increased Test Acceptance*

*Greater Exposure to HIV Testing*

The majority of testers are employed where opportunities to access VCT are readily available. Being a student is also associated with a greater likelihood of VCT exposure. The majority of non-testers are unfortunately unemployed and do not enjoy these privileges since VCT is not a visible sight within their communities; and the majority of non-testers are not in favour of testing in the public sector.

*Increased Options*

The majority of testers have access to medical aid. Being employed further allows them to a greater extent to pay cash for health services. Non-testers primarily access health services on a cash basis. Since the majority of them are dependant on their parents for financial assistance, they might not always have the cash to access private sector services. The majority of testers and non-testers indicated that they prefer to access private sector services. Financial constraints and persistent negative perceptions about public sector service delivery might therefore pose as a barrier to HIV testing.

*Other characteristics*

The majority of testers have higher levels of education than non-testers; a factor frequently associated with a higher likelihood of test acceptance in previous studies. Previous studies further equate increased testing with increasing age: 29-39 years. The average age of testers and non-testers are 23 years and 21 years respectively.

*6.9 Summary of Key Findings and Concluding Remarks*

The majority of participants in this study are not tested for HIV. This finding is line with previous research conducted in South Africa, Africa and internationally. The majority of testers plan on going for testing in future. The question remains regarding the likelihood that these testing intentions will be realized since the majority of previous studies have indicated that people do not act out what they say when it comes to HIV testing. Both testers and non-testers discern many VCT-related benefits. Two major benefits that they have mentioned are the physical and psychological benefits associated with knowledge of your HIV status. Participants frequently referred to how it enables an individual to take precautionary measures dependent on the outcome of the result. They further referred to the relief that certainty regarding your HIV status provides. None of the participants mentioned access to medicinal or treatment as benefits of HIV testing. The greatest disadvantages related to HIV testing as discerned by participants include anticipating the consequences of a possible HIV positive result; and the long waiting periods for testing results that only exacerbates stress and anxiety.

The main reasons behind HIV testing include testing as a prerequisite of an insurance policy application. Most testers were motivated by personal and interpersonal reasons to go for HIV testing but they were presented with the opportunity to test; i.e. testing found them. The question remains as to whether they would have gone out of their own free will to search for VCT were they not presented with these opportunities. Only one participant actively went to seek out HIV testing. Participants are highly motivated by convenience and ease of access when considering HIV testing. Testing must be close in proximity and it must be rapid and efficient. Some of the non-testers indicated a lack of time as main reason why they are not tested for HIV. Most participants mentioned that the reason why they accepted testing is the fact that it was nearby and immediately available to them.

Fear, followed by a low perception of risk represents the most predominant barriers to HIV testing. Fear is described as psychological entrenched; it is a fear evoked when anticipating the negative consequences of testing HIV positive. It is a fear that evokes hopelessness and fatalism. Participants further fear blame and rejection by others. The majority of participants, both testers and non-testers, perceive themselves to be at very low risk of contracting the HI-virus. The most frequently sited reasons for this low perception of risk, in descending order of frequency, is having sex with only one partner; and the use of condoms at all times during sexual intercourse.

This over-reliance on monogamous relationships as method of prevention of HIV transmission raises concerns as to how safe these relationships indeed are. Some interview and focus group participants have mentioned stable relationships as motivator to HIV testing. The question remains as to the possibility that VCT is used as a validation for continuous unprotected sex (Solomon et al, 2004).

Low perception of risk among participants is confirmed by the fact that some participants see HIV testing as a way to prove or confirm an HIV negative status. Participants are concerned about maintaining their good name and image since some participants have frequently mentioned disclosure of HIV status only in instances where the result is negative. It raises concerns about pressure placed on certain individuals to keep quiet and to live in denial; especially considering the fact that jokes and teasing among team mates about HIV and AIDS are a common sight. There is also a suspicion that teasing might contribute to why many participants avoid HIV testing. There is no certainty regarding the extent to which teasing functions as a barrier to HIV testing. Low perception of risk might cause some participants to not view HIV testing as an urgent priority, unless they enter a serious relationship or in the pursuit of marriage. Other concerns regarding low risk perception is the fact that some participants validate it by means of an absence of symptoms hinting at possible HIV infection, or the fact that participants have previously tested for HIV. The latter reason raises concerns because of the fact that participants might mistakenly view VCT as a prevention method on its own.

Perceptions about the public health sector might pose as another barrier to HIV testing. The majority of non-testers prefer testing in the private sector because they associate it with increased levels of neatness; privacy and confidentiality; safety and sufficiency; and competence. The majority of non-testers, however, has no access to medical aid and use cash to access health care services. They are further unemployed and dependent on financial assistance from parents. They might therefore resist VCT at public health institutions based on their perceptions. Testers similarly expressed these negative perceptions regarding public sector health. An increased likelihood of testing in this study is associated with being either employed, or a student since these provide greater exposure to, and opportunities for HIV testing by means of VCT awareness campaigns. It is also associated with having access to medical aid and earning an income since these provide you with alternative options for testing.

Other concerns emerging from the study is the fact that 50% of testers did not receive any form of counseling. This is unacceptable considering the serious implications of an HIV positive result. Counseling is crucial since most of the participants have very fatalistic views about testing HIV positive. Counseling provides participants with some of the necessary coping skills and increased access to other forms of support. Some of the non-testers expressed concerns about inappropriate disclosure of the HIV status by family members. Counseling enables the individual to counter the effects of this form of disclosure.

This study has found no meaningul relationship between perceived and personal stigma, and HIV testing. Both testers and non-testers hold no to low perceptions of community stigma and family related stigmatizing attitudes. Testers seem to hint more at support of certain stigmatizing attitudes toward PWA’s than non-testers. Overall, the majority of participants have no strong and persistent stigmatizing attitudes, thus suggesting that people are becoming more sensitized and accepting toward PWA’s. These, coupled with positive attitudes expressed toward HIV testing should contribute to an environment more conducive to HIV testing.

*6.10 Recommendations*

- The need to be psychologically well is a predominant expectation of most males who have participated in this study. Alternative ways of constructive coping should therefore be extensively explored. People should be equipped with the necessary coping skills in order to counter the effects of a positive result. Reference is made in Solomon et al (2004) to the failure of Western biomedicine to integrate spirituality and faith into the healing paradigm for terminal illness. Medical anthropologists refer to two inter-related, but separate, healing functions (Solomon et al, 2004). These are the control of illness and the provision of meaning for the individual's experience of sickness. They contend that problems arise when emphasis is primarily placed on disease rather than having consideration for the person's illness experience. One of the VCT counselors at the Rosedale clinic says that she incorporates spirituality with counseling in assisting HIV positive people to cope and clients, in the majority of cases, demand to be counseled by her. The role of religion or faith in countering fatalism and fear should not be underestimated. It should be the driving force behind fostering positive ways of coping, providing individuals with much needed spiritual guidance and support.

- The church should further pursue the leading role in the promotion of abstinence to counter this over reliance on condom use and mutual monogamy; both not considered bulletproof shields against HIV infection. The church should define abstainence and should provide clear explanations of how this goal can be pursued and achieved. One of the participants, 18 years of age, was bold enough to state that his low perception of risk is attributed to abstinence.

- Most testers were presented with an opportunity to test since they are increasingly being exposed to testing at their place of work or study. The chances of non-testers being exposed to VCT are very slim since the majority of them are unemployed, and VCT is not vigorously promoted within their communities. VCT

is still perceived as a secretive and hidden process, only reserved for certain individuals. Pregnant women remain the primary beneficiaries of routine HIV testing at the Rosedale clinic to prevent the transmission from the mother to the baby. The presence of VCT should be made felt within the communities where these males are resident. The majority of testers and non-testers perceived immense benefits linked to knowing your status. Hence, this should be exploited as a platform for VCT. VCT must be made readily available by means of active campaigning without any form of coercion. Mobile VCT sites can be erected for purposes of convenience, a prerequisite for effective use of VCT services mostly referred to by males. Rapid testing must be employed since the majority of testers are in favour of it for various reasons. Visibility of VCT and the fact that it becomes a familiar sight in communities might contribute to reduce perceptions of VCT as a service that needs to be practiced in isolation, only reserved for certain targeted populations.

- It is vital to address present insufficiencies in the public health sector. The resource backlog should enjoy urgent attention and steps should proactively be taken to remedy this problem. More nurses and counselors should be trained and employed in order to serve this mounting and demanding client base. This would simultaneously address perceptions of services being conducted haphazardly in order to accommodate all clients. Testing sites within these settings should not be situated in designated or marked areas where it runs the risk of being labeled or stigmatized by clients and the community in general. It should be rotated where possible, and integrated with the rest of the services on offer to demolish secrecy commonly associated with VCT services. All health care facilities should be kept neat and tidy at all times and this is the responsibility of both staff and clients. Active steps must be taken to address the lack of trust between staff members and clients since the lack of trust is a breeding ground for division, not considered conducive for development. There should be opportunities for open dialogue where the concerns of both the community and clinic staff should be raised and actively addressed. Continuous feedback should be given and all the involved

stakeholders should be held accountable for monitoring progress. Community members should be given the opportunity to actively participate within clinic structures and should be granted the opportunity to deliver inputs where important decisions affecting them are made. This will hopefully contribute to heighten ownership and a sense of unity reinforcing the idea that community and staff members are not on opposite sides of the fence but that they should work side by side toward a common goal.

- Involvement of both males and females are crucial in the maintenance of reproductive health and in the management of HIV and AIDS. More initiatives should be undertaken to actively engage males in reproductive health initiatives. Initiatives such as Men as Partners (MAP) prove effective in achieving this goal. Peer educators presents as another way of encouraging males to take ownership, firstly of their own health and secondly, that of others. It is premised on the principles of being a role model; a referral source; an advocate; an educator; and an activist. These rugby players have gained credibility within their communities and most young people already regard them as role models and trendsetters. Teasing and jokes are not a phenomenon exclusive to rugby players but it can be constructively applied to counter its own effects. Most males adhere to group principles since they do not want to be perceived as deviants. Peer educators should be promoted in an enticing way causing every male to desire to be part of it. Males must be encouraged to know their status irrespective of the outcome of the result and to assume responsibility for it.

- A review of VCT counseling methods should be employed to determine its efficacy within the South African context. Counselors should be made thoroughly aware of how they should conduct themselves during VCT. Inappropriate behaviour elicited by them might discourage clients from presenting for testing in future; or clients might advice others against testing based on their experience.

- Where stigmatizing attitudes persist, greater effort must be made to cultivate a culture of learning among those who are ignorant or those who do not have adequate knowledge. People should be challenged to take initiative and to seek out information rather than overwhelming them with massive volumes of information. They should also be encouraged to take initiative by reaching out to PWA's. Community members who do not have sufficient access to information must also be enlightened about their rights as potential VCT clients, or HIV infected individuals.

**Appendix A: Questionnaire**

# MALES AND HIV TESTING

**NO:** ☐

## A. DEMOGRAPHIC INFORMATION

**1. Age:** ☐

**2. Rugby Club:** _____

**3. Race:** **Black** ☐ **Coloured** ☐ **White** ☐ **Indian** ☐

**Other: Please Specify** _____

**4. Marital Status: Married** ☐ **Not Married** ☐ **Divorced** ☐

**5. Area of Residence:** _____

**6. Highest Educational Attainment (completed grade at school or diploma/degree obtained):**

_____

**7. Are you currently employed? (Those not available for employment are excluded e.g. full-time caregivers, students, learners, and those unwilling to work.)**

YES ☐ NO ☐

**8. Were you employed 7 days prior to this interview?**

YES ☐ NO ☐

**9. List your primary means of income.**

_____

**10. Dependents (people you support financially):** **Yes** ☐ **No** ☐

**11. IF YES TO QUESTION 10: Please indicate number of depend** ☐

**12. How do you finance your medical services?**

**Cash** ☐

**Medical Aid** ☐

**State Subsidized** ☐

**Other (please specify):** _____

**13. How frequently do you visit the doctor or clinic?**

Weekly ☐

Monthly ☐

Annually ☐

Only if necessary ☐

Never ☐

**14. Have you previously heard of Voluntary Counseling and Testing (VCT?)**

YES ☐ NO ☐

**15. IF YES TO QUESTION 14- How have you heard about it? (Please list all possible sources)**

……
……

**16. What do you understand by VCT?**

……
……
……

**17. What are your chances of testing HIV positive should you decide to go for testing? (Low/ Medium/ High probability)**

……
……
……
……

**18. Have you previously tested for HIV?**

YES ☐ NO ☐

**QUESTIONS 19 TO 41 ARE ONLY FOR THOSE PARTICIPANTS WHO RESPONDED "YES" TO QUESTION 18. PLEASE PROCEED TO QUESTION 42 IF YOU RESPONDED "NO".**

**19. How many times have you gone for HIV testing?**

☐

**20. Please list all possible reasons why you went for HIV testing:**

……
……
……
……
……

**21. Where did you access the test? Please provide reasons for why you have accessed testing there?**

**(In case of a public clinic- please specify the name)**

……
……
……
……

**22. If you have not accessed VCT at Rosedale Clinic and you live close by; why have you not accessed testing there?**

……
……
……
……
……

**23. Did you receive counseling prior to the test?**

YES ☐ NO ☐

**24. IF NO TO QUESTION 23:Why not?**

……
……
……
……

**25. Did you receive counseling after testing?**

YES ☐ NO ☐

**26. IF NO TO QUESTION 25: Why not?**

……
……
……
……

**27. Did the same person conduct pre- and post test counseling?**

YES ☐ NO ☐

**28. Was your blood taken by the same person who administered counseling?**

YES ☐ NO ☐

**29. Please describe the personality of the following individual (s): (e.g. warm, hostile, sympathetic, insensitive, friendly, rude):**

**Counselor 1:**
……..

**Counselor 2:**
……..

**Person who took your blood:**
……

**30. Did you receive your test results?**

YES ☐ NO ☐

**31. IF "NO" TO QUESTION 30: Please provide reasons why you have not received your test results:**

……
……
……

**32. IF "YES" TO QUESTION 30: Please specify how long you have waited for your results?**

**Same day** ☐

**1 to 3 weeks** ☐

**4 plus weeks** ☐

**33. How do you feel about the time you had to wait for test results?**

……
……
……

**34. Did they put your name on the testing form?**

YES ☐ NO ☐

**35. IF "YES" TO QUESTION 34: How do you feel about that?**

……
……
……

**36. Describe the room where counseling/testing was conducted. Would you say that it is conducive to counseling/testing?**

……
……
……

**37. Have you told anyone that you have gone for HIV testing? Please motivate.**

……
……
……

**38. IF "YES" TO QUESTION 37: Please specify whom you have told:**

……

**39. What are the good things that stood out from the VCT/HIV testing experience?**

……
……
……

**40. What are the bad things that stand out from the testing experience?**

……
……
……
……

**41. Would you motivate others to go for HIV testing? Please motivate:**

……
……
……



**QUESTIONS 42 TO 49 ARE ONLY FOR THOSE INDIVIDUALS WHO HAVE RESPONDED NO TO QUESTION 18:**

**42. List all the possible reasons why you have not yet gone for HIV testing:**

……
……
……
……
……
……
……
……
……

**43. Will you consider going for testing in the near future (following 3 to 6 months)?**

YES ☐ NO ☐

**44. Where would you access testing? (IF "YES" TO QUESTION 43)**

**Private Doctor** ☐

**Private clinic** ☐

**Public clinic** ☐

**Public hospital** ☐

**Other (please specify):** _____

**45. Please motivate your preference provided to question 44:**

……
……
……

**46. What, according to you, is the characteristics of a suitable VCT site?**

……
……
……
……
……

**47. What, according to you, are the characteristics, of a suitable counselor?**

……
……
……

**48. How can you benefit from VCT?**

……
……
……
……

**49. What are the disadvantages linked to VCT?**

……
……
……
……
……
……

**THE FOLLOWING SET OF QUESTIONS IS FOR BOTH TESTERS AND NON-TESTERS.**

**Please select the number that best expresses your view:**

**1. Agree**
**2. Strongly Agree**
**3. Disagree**
**4. Strongly Disagree**

| | | | | |
|---|---|---|---|---|
| 50. People in my community do not talk to you if you are HIV positive | **1** | **2** | **3** | **4** |
| 51. People in my community do not want to be friends with you if you are HIV positive | **1** | **2** | **3** | **4** |
| 52. People in my community gossip about those individuals that are HIV positive | **1** | **2** | **3** | **4** |
| 53. People in my community are capable of violence toward people with AIDS (PWA's) | **1** | **2** | **3** | **4** |
| 54. In my community it is considered a disgrace if you test HIV positive | **1** | **2** | **3** | **4** |
| 56. Nobody in my community talk about HIV and AIDS | **1** | **2** | **3** | **4** |
| 57. My family will not eat from the same plate as I should I test HIV positive | **1** | **2** | **3** | **4** |
| 58. My family will disown me if I test HIV positive | **1** | **2** | **3** | **4** |
| 59. My family will keep my HIV status secret should I test HIV positive | **1** | **2** | **3** | **4** |
| 60. I will feel ashamed if someone sees me at an HIV testing site | **1** | **2** | **3** | **4** |
| 61. HIV positive people are dirty | **1** | **2** | **3** | **4** |
| 62. I will never drink from the same cup as someone who is HIV positive | **1** | **2** | **3** | **4** |
| 63. HIV positive people deserve their pain and suffering | **1** | **2** | **3** | **4** |
| 64. I will pursue a friendship with an HIV positive individual | **1** | **2** | **3** | **4** |
| 65. I will hug someone that is HIV positive | **1** | **2** | **3** | **4** |
| 66. HIV positive people are irritable | **1** | **2** | **3** | **4** |
| 67. I hate HIV positive people | **1** | **2** | **3** | **4** |
| 68. I think it is a disgrace if you are HIV positive | **1** | **2** | **3** | **4** |
| 69. HIV positive people should stay on island on their own | **1** | **2** | **3** | **4** |
| 70. I will openly talk about my HIV status should I test HIV positive | **1** | **2** | **3** | **4** |

*THANK YOU FOR YOUR TIME AND CO-OPERATION*

| Table 5- Perceived Stigma and Stigmatizing Attitudes | | | | | | |
|---|---|---|---|---|---|---|
| **5.6.1 PERCEPTIONS OF STIGMA WITHIN COMMUNITIES** | | | | | | |
| | Agree | Strongly Agree | Total | Disagree | Strongly Disagree | Total |
| **1. People in my community do not talk to you if you are HIV positive.** | | | | | | |
| Testers (T) | 2 (33%) | 2 (33%) | 4 (67%) | 2 (33%) | 0 | 2 (33%) |
| Non-testers (N) | 6 (50%) | 0 | 6 (50%) | 5 (42%) | 1 (8%) | 6 (50%) |
| **Total** | **8 (44%)** | **2 (33%)** | **10 (56%)** | **7 (39%)** | **1 (8%)** | **8 (44%)** |
| **2. People in my community do not want to be friends with you if you are HIV positive** | | | | | | |
| (T) | 1 (17%) | 2 (33%) | 3 (50%) | 2 (33%) | 1 (17%) | 3 (50%) |
| (N) | 4 (33%) | 0 | 4 (33%) | 7 (58%) | 1 (8%) | 8 (67%) |
| **Total** | **5 (28%)** | **2 (11%)** | **7 (39%)** | **9 (50%)** | **2 (11%)** | **11 (61%)** |
| **3. People in my community gossip about those who are HIV positive** | | | | | | |
| (T) | 2 (33%) | 4 (67%) | 6 (100%) | 0 | 0 | |
| (N) | 4 (33%) | 8 (67%) | 12 (100%) | 0 | 0 | |
| **Total** | **6 (33%)** | **12 (67%)** | **18 (100%)** | **0** | **0** | |
| **4. People in my community are capable of becoming violent toward those that are HIV positive** | | | | | | |
| (T) | 2 (33%) | 1 (17%) | 3 (50%) | 2 (33%) | 0 | 2 (33%) |
| (N) | 1 (8%) | 1 (8%) | 2 (17%) | 7 (58%) | 3 (25%) | 10 (83%) |
| **Total *One of the testers was unsure** | **3 (17%)** | **2 (11%)** | **5 (28%)** | **9 (50%)** | **3 (17%)** | **12 (67%)** |
| **5. It is a disgrace in my community if somebody tests HIV** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **positive** | | | | | | |
| (T) | 0 | 2 (33%) | 2 (33%) | 4 (67%) | 0 | 4 (67%) |
| (N) | 3 (25%) | 1 (8%) | 4 (33%) | 7 (58%) | 1 (8%) | 8 (67) |
| **Total** | **3 (17%)** | **3 (17%)** | **6 (33%)** | **11 (61%)** | **1 (8%)** | **12 (67%)** |
| **6. Nobody in my community talks about HIV/AIDS** | | | | | | |
| (T) | 2 (33%) | 0 | 2 (33%) | 2 (33%) | 2 (33%) | 4 (67%) |
| (N) | 4 (33%) | 2 (17%) | 6 (50%) | 6 (50%) | 0 | 6 (50%) |
| **Total** | **6 (33%)** | **2 (17%)** | **8 (44%)** | **8 (44%)** | **2 (33%)** | **10 (56%)** |

| 5.6.2 PERCEPTIONS OF FAMILY'S ATTITUDE TOWARD PEOPLE WITH AIDS (PWA'S | | | | | | |
|---|---|---|---|---|---|---|
| | Agree | Strongly Agree | Total | Disagree | Strongly Disagree | Total |
| **7. My family would not eat from the same plate as I should I test HIV positive** | | | | | | |
| (T) | 0 | 1 (17%) | 1 (17%) | 3 (50%) | 1 (17%) | 4 (67%) |
| (N) | 2 (17%) | 0 | 2 (17%) | 5 (42%) | 5 (42%) | 10 (83%) |
| **Total *One of the testers was unsure** | **2 (17%)** | **1 (17%)** | **3 (17%)** | **8 (44%)** | **6 (33%)** | **14 (78%)** |
| **8. My family would disown me should I test HIV positive** | | | | | | |
| (T) | 0 | 0 | 0 | 6 (100%) | 0 | 6 (100%) |
| (N) | 1 (8%) | 0 | 1 (8%) | 5 (42%) | 6 (50%) | 11 (92%) |
| **Total** | **1 (8%)** | **0** | **1 (8%)** | **11 (61%)** | **6 (33%)** | **17 (94 %)** |
| **9. My family would keep it a secret should I test HIV positive** | | | | | | |
| (T) | 2 (33%) | 1 (17%) | 3 (50%) | 3 (50%) | 0 | 3 (50%) |
| (N) | 3 (25%) | 2 (17%) | 5 (42%) | 6 (50%) | 1 (8%) | 7 (58%) |
| **Total** | **5 (28%)** | **3 (17%)** | **8 (44%)** | **9 (50%)** | **1 (8%)** | **10 (56%)** |

| 5.6.3 PERSONAL STIGMATIZING ATTITUDE TOWARD PWA'S | | | | | | |
|---|---|---|---|---|---|---|
| | Agree | Strongly Agree | Total | Disagree | Strongly Disagree | Total |
| **10. I'll feel ashamed if someone familiar sees met at an HIV testing site** | | | | | | |
| (T) | 0 | 1 (17%) | 1 (17%) | 3 (50%) | 2 (33%) | 5 (83%) |
| (N) | 2 (17%) | 0 | 2 (17%) | 4 (33%) | 6 (50%) | 10 (83%) |
| **Total** | **2 (11%)** | **1 (6%)** | **3 (17%)** | **7 (39%)** | **8 (44%)** | **15 (83%)** |
| **11. HIV positive people are dirty** | | | | | | |
| (T) | 0 | 0 | 0 | 5 (83%) | 1 (17%) | 6 (100%) |
| (N) | 0 | 0 | 0 | 8 (67%) | 4 (33%) | 12 (100%) |
| **Total** | **0** | **0** | **0** | **13 (72%)** | **5 (28%)** | **18 (100%)** |
| **12. I'll never drink from the same cup as someone who's HIV positive** | | | | | | |
| (T) | 1 (17%) | 0 | 1 (17%) | 3 (50%) | 1 (17%) | 4 (67%) |
| (N) | 3 (25%) | 0 | 3 (25%) | 5 (42%) | 4 (33%) | 9 (75%) |
| **Total** | **4 (22%)** | **0** | **4 (22%)** | **8 (44%)** | **5 (28%)** | **13 (72%)** |
| **13. HIV positive people deserve their illness and suffering** | | | | | | |
| (T) | 0 | 0 | 0 | 5 (83%) | 0 | 5 (83%) |
| (N) | 1 (8%) | 0 | 1 (8%) | 6 (50%) | 5 (42%) | 11 (61%) |
| **Total *One of the testers was not able to make a chaice** | **1 (8%)** | **0** | **1 (8%)** | **11 (61%)** | **5 (28%)** | **16 (89%)** |
| **14. I will start a friendship with an HIV positive person** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| (T) | 4 (67%) | 2 (33%) | 6 (100%) | 0 | 0 | 0 |
| (N) | 8 (67%) | 3 (25%) | 11 (92%) | 0 | 1 | 1 (6%) |
| **Total** | **12 (67%)** | **5 (28%)** | **17 (94%)** | **0** | **1 (6%)** | **1 (6%)** |
| **15. I will hug someone who is HIV positive** | | | | | | |
| (T) | 4 (67%) | 2 (33%) | 6 (100%) | 0 | 0 | 0 |
| (N) | 9 (75%) | 3 (25%) | 12 (100%) | 0 | 0 | 0 |
| **Total** | **13 (72 %)** | **5 (28%)** | **18 (100%)** | **0** | **0** | **0** |
| **16. HIV positive people are irritable** | | | | | | |
| (T) | 0 | 0 | 0 | 3 (50%) | 2 (33%) | 5 (83%) |
| (N) | 0 | 0 | 0 | 8 (67%) | 4 (33%) | 12 (100%) |
| **Total *One of the testers was unsure** | **0** | **0** | **0** | **11 (61%)** | **6 (33%)** | **17 (94%)** |
| **17. I hate HIV positive people** | | | | | | |
| (T) | 0 | 0 | 0 | 4 (67%) | 2 (33%) | 6 (100%) |
| (N) | 0 | 0 | 0 | 6 (50%) | 6 (50%) | 12 (100%) |
| **Total** | **0** | **0** | **0** | **10 (56%)** | **8 (44%)** | **18 (100%)** |
| **18. I think it is a disgrace if you test HIV positive** | | | | | | |
| (T) | 1 (17%) | 0 | 1 (17%) | 3 (50%) | 2 (33%) | 5 (83%) |
| (N) | 1 (8%) | 1 (8%) | 2 (17%) | 6 (50%) | 4 (33%) | 10 (56%) |
| **Total** | **2 (11%)** | **1 (8%)** | **3 (17%)** | **9 (50%)** | **6 (33%)** | **15 (83%)** |
| **19. HIV positive people should stay on an island on their own** | | | | | | |
| (T) | 0 | 0 | 0 | 3 (50%) | 3 (50%) | 6 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | (100%) |
| (N) | 1 (8 %) | 0 | 1 (8%) | 4 (33%) | 7 (58%) | 11 (92%) |
| **Total** | **1 (8%)** | **0** | **1 (8%)** | **7 (39%)** | **10 (56%)** | **17 (94%)** |
| **20. I will openly talk about my status should I test HIV positive** | | | | | | |
| (T) | 0 | 1 (17%) | 1 (17%) | 5 (83%) | 0 | 5 (83%) |
| (N) | 6 (50%) | 3 (25%) | 9 (50%) | 2 (17%) | 1 (8%) | 3 (25%) |
| **Total** | **6 (50%)** | **4 (22%)** | **10 (56%)** | **7 (39%)** | **1 (6%)** | **8 (44%)** |

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